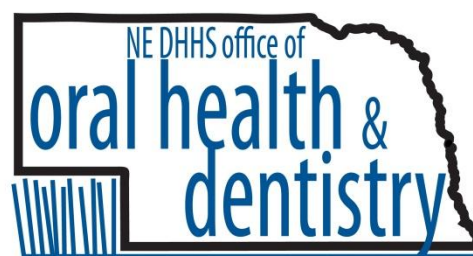


Oral Health Access for Young Children Program Final Report

January 2011 – August 2012



Nebraska Department of Health and Human Services

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Acknowledgements

The Oral Health Access for Young Children (OHAYC) program was funded by the Health Resources and Services Administration's *Grants to States to Support Oral Health Workforce Activities* Grant #T12HP14997.

Thanks to the regional and community partners who helped administer and implement the OHAYC program.

The Two Rivers Public Health Department's Young Children Priority One program (YCPO) served as the pilot project for OHAYC, and provided key leadership and guidance in shaping and administering the statewide program.

Creighton University's Center for Health Services Research and Patient Safety (CHRP) provided vision and expertise throughout the planning, implementation, and evaluation of the OHAYC program.

The University of Nebraska Medical Center College of Public Health Department of Biostatistics provided the framework for much of the quantitative analysis in this report.

Thanks to our internal partners at Nebraska Department of Health and Human Services and to the Office of Oral Health and Dentistry's Oral Health Advisory Panel for lending their perspectives, insights and encouragement throughout the life of the OHAYC program.

Thanks to Proctor & Gamble and to the Public Health Association of Nebraska for their support of this program.

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Oral Health Access for Young Children Overview

When: January 2011 – August 2012

What: The Oral Health Access for Young Children (OHAYC) program provided preventive dental screenings and supplies, fluoride varnish applications, oral health education and dental referrals to high-risk children and families with limited access to dental health care.

Who:

Government →

- Health Resources & Services Administration
- Nebraska DHHS

Local Partners →

- Public Health Departments
- Community Health Centers
- Dental Hygiene teams

Community Sites →

- WIC Clinics
- Head Start Programs
- Child Care – Preschools

Children & Families

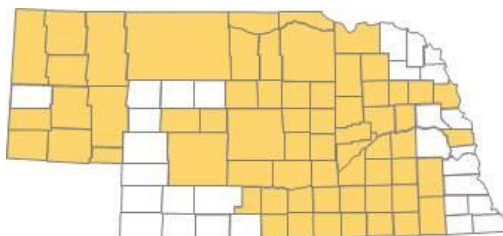
- High Need
- Limited Access
- Rural & Urban

How: The OHAYC program was funded by the Health Resources and Services Administration (HRSA) through a 3-year grant program: *Grants to States to Support Oral Health Workforce Activities*, Grant #T12HP14997. Of this grant, \$890,000 was distributed to partner organizations across the state to implement and evaluate OHAYC.

Why:

- Tooth decay causes pain and can affect how kids eat, speak, play, learn and grow.¹
- A 2005 survey of Nebraska 3rd graders showed that almost 60% had tooth decay.²
- Children living in rural areas of Nebraska are more likely to have oral health problems.³
- Children in Nebraska without private insurance are more likely to have poor oral health.⁴
- Nebraska children whose primary language is not English are over 10 times more likely to have poor oral health.⁵
- Of 43 pediatric dentists in 2011, only seven were located outside of Omaha and Lincoln.
- Fluoride varnish can effectively prevent tooth decay in high-risk children.⁶

Where: The Local Health Departments and Federally Qualified Health Center partners represented 64 of Nebraska's 93 counties.



Nebraska

Population: **1,826,341**
23.8 People/mi²

Land Area: **76,824.2** mi²
1,169 People/Dentist

Dentists: **1,562**
49.2 mi²/Dentist

Dental Hygienists: **1,261**
0.81 RDH/Dentist

Outcomes

Children Seen: **19,086**

Client Visits: **26,131**

Fluoride Varnish Treatments: **24,167**

Clinic Hours: **6,813**

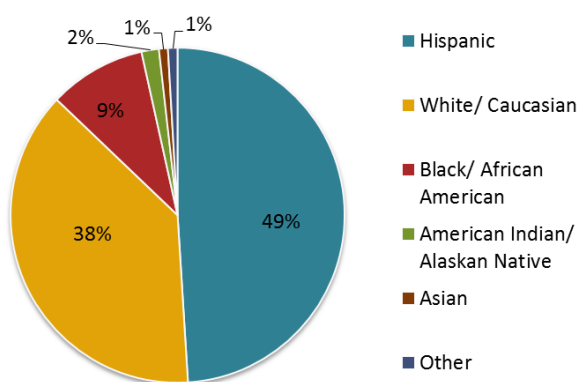
Community Site – WIC: **53**

Staff involved with project: **62**

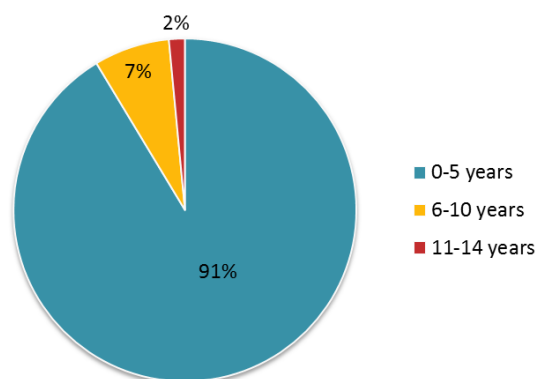
Satisfaction Rate (WIC): **96%**

Intended/Actual Referral Rate (WIC): **95%**

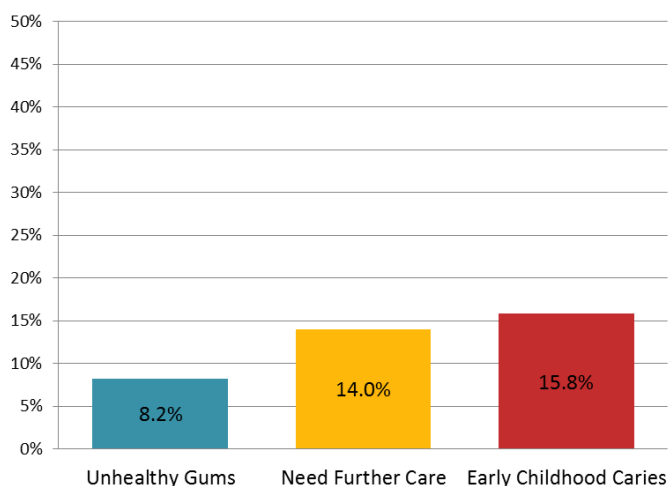
OHAYC Racial Ethnic Distribution



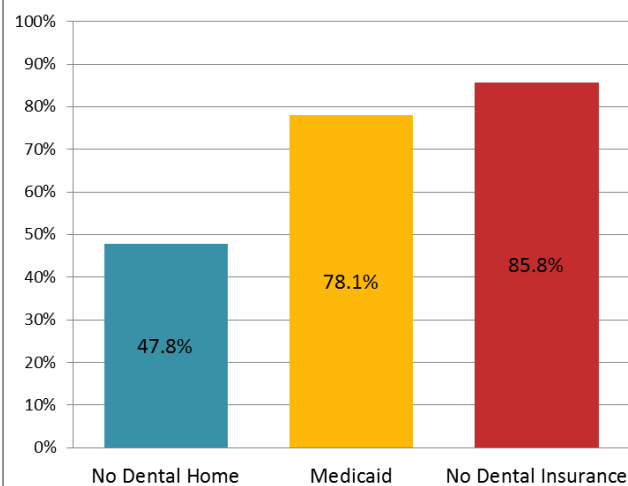
OHAYC Age Distribution



OHAYC Oral Health Status



OHAYC Access to Oral Health Care



Evaluation

Independent evaluation by the Creighton University Center for Health Services Research and Patient Safety (CHRP) concluded that OHAYC successfully expanded the Young Children Priority One pilot program model to communities across the state and demonstrated the ability to successfully reach high-risk families and children with preventive services in both urban and rural areas. They report that parents were very satisfied with the services provided and were likely to refer others to the program, and that the OHAYC program increased the confidence of parents and guardians in their ability to prevent decay in children's teeth. CHRP also reported that this program increased the capacity of local communities to improve the oral health of children through the initiation and development of new partnerships, and was strengthened by a focus on influencing parental behavior through education.

The OHAYC program provides a promising model for provision of dental services to communities and populations with limited access to care that are traditionally hard to reach. For a few local health departments, this program was the first to prioritize oral health since the health department had been established. Prior to the conclusion of this project period, local communities were at the threshold of adapting the programs even further to incorporate their own needs and local resources by adding components such as dental sealants, mobile dental clinics, school-based services, and increased collaboration with local dentists. Eleven out of the 15 grantees indicated that they intend to continue the program in some capacity after the loss of continuation funding in August 2012.

For a detailed chart of the OHAYC program model, see Appendix A on page 29.

Program Summaries

The following pages outline program summaries for each of the fifteen OHAYC partner programs. Here are the sources that were used to put together this information.

Health Department data were calculated based on information from:

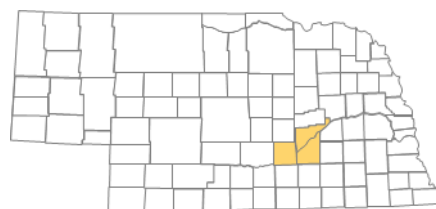
- US Census Bureau, State and County Quick Facts for Nebraska
 - <http://quickfacts.census.gov/qfd/states/31000.html>
- DHHS Dental Licensing information as of December 31, 2012
 - <https://www.nebraska.gov/hhs/lists/search.cgi>

Outcomes data were collected from:

- OHAYC Monthly and Annual Report Forms
- OHAYC Dental Screening Forms
- OHAYC Parent Satisfaction Surveys

To see examples of these forms, see Appendix B on page 30.

Central District Health Department



Population: **72,447**
46 People/mi²

Land Area: **1,575** mi²
1,393 People/Dentist

Dentists: **52**
30.3 mi²/Dentist

Dental Hygienists: **51**
0.98 RDH/Dentist

Outcomes

Children Seen: **2,110**

Client Visits: **3,030**

Fluoride Varnish Treatments: **3,451**

Clinic Hours: **871**

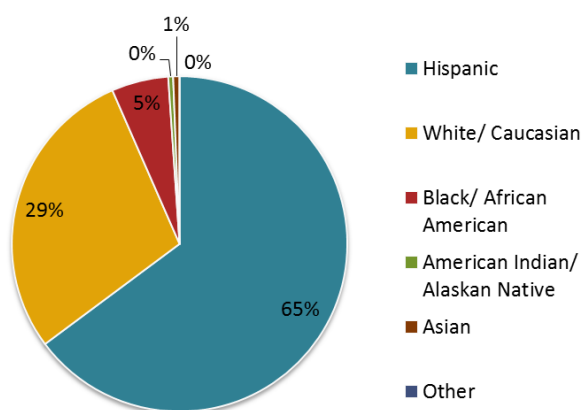
Community Site – WIC: **1**

Staff involved with project: **3**

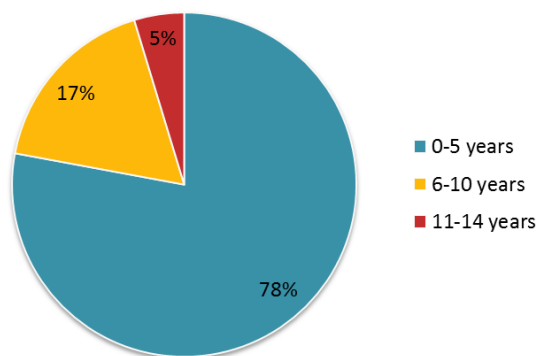
Satisfaction Rate (WIC): **99%**

Intended/Actual Referral Rate (WIC): **95%**

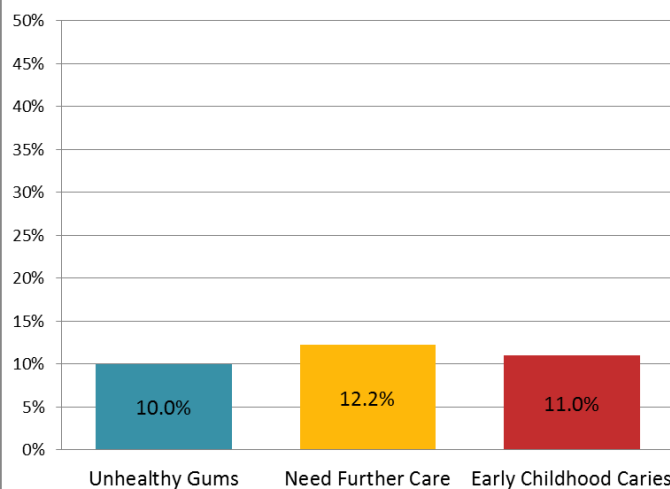
CDHD Racial Ethnic Distribution



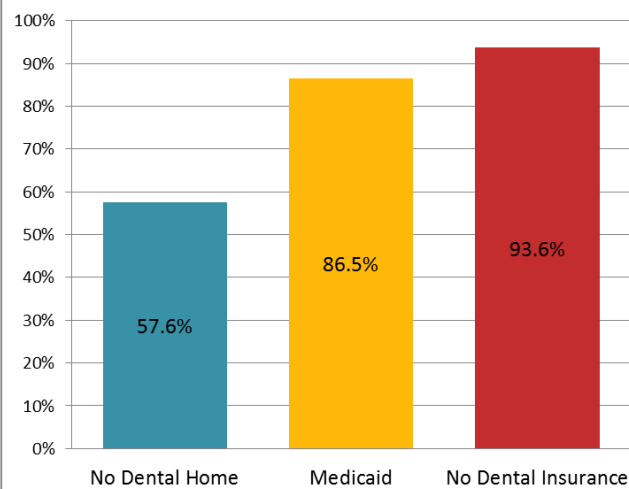
CDHD Age Distribution



CDHD Oral Health Status



CDHD Access to Oral Health Care



Charles Drew Community Health Center



Population: **482,112** Land Area: **331 mi²**
1,456.6 People/mi² **1,048** People/Dentist

Dentists: **460**
0.7 mi²/Dentist

Dental Hygienists: **285**
0.6 RDH/Dentist

Outcomes

Children Seen: **1,959**

Client Visits: **4,056**

Fluoride Varnish Treatments: **2,701**

Clinic Hours: **1,065**

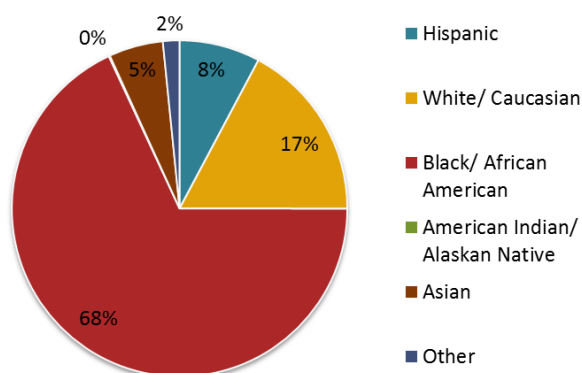
Community Site – WIC: **1**

Staff involved with project: **5**

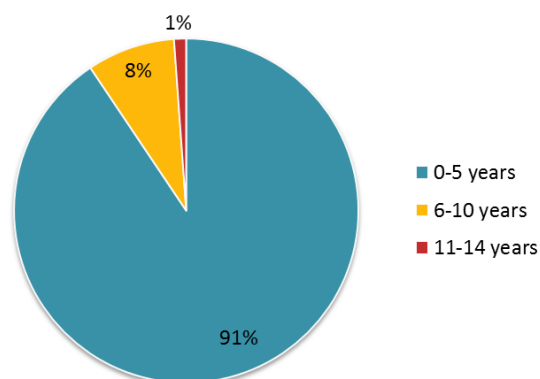
Satisfaction Rate (WIC): **79%**

Intended/Actual Referral Rate (WIC): **87%**

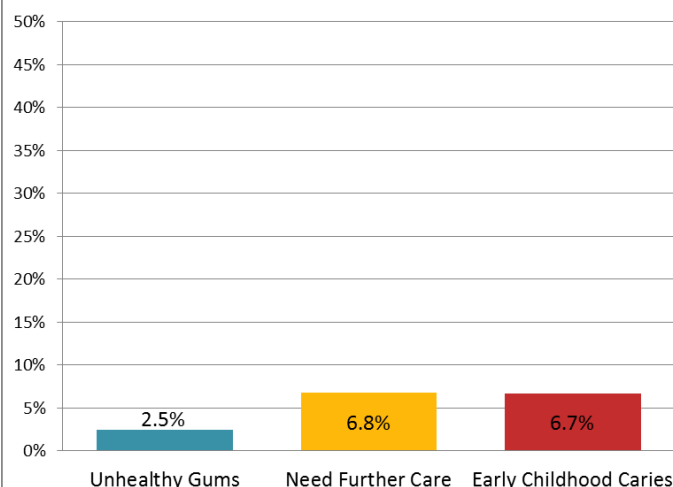
CDCHC Racial Ethnic Distribution



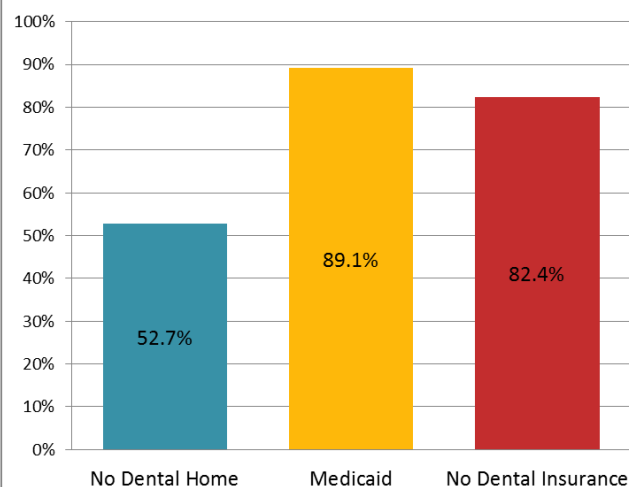
CDCHC Age Distribution



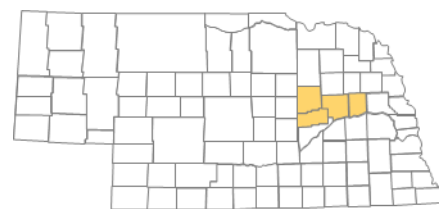
CDCHC Oral Health Status



CDCHC Access to Oral Health Care



East Central District Health Department



Population: **51,325**
23.1 People/mi²

Land Area: **2,219.2** mi²
2,333 People/Dentist

Dentists: **22**
100.9 mi²/Dentist

Dental Hygienists: **28**
1.3 RDH/Dentist

Outcomes

Children Seen: **1,309**

Client Visits: **1,963**

Fluoride Varnish Treatments: **1,831**

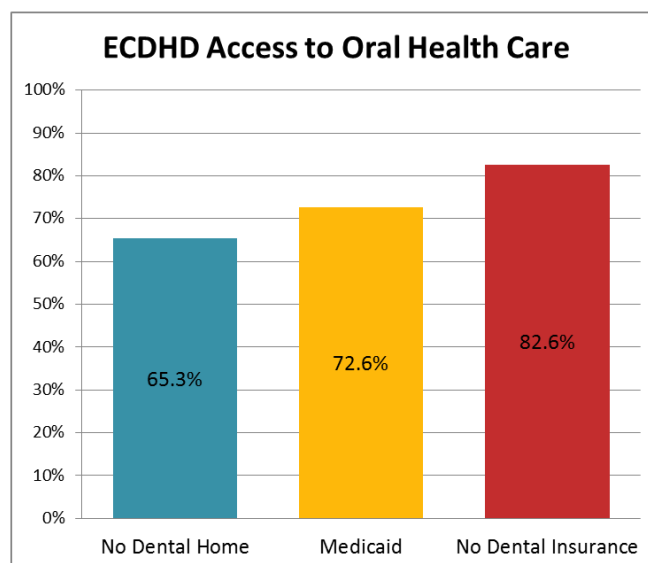
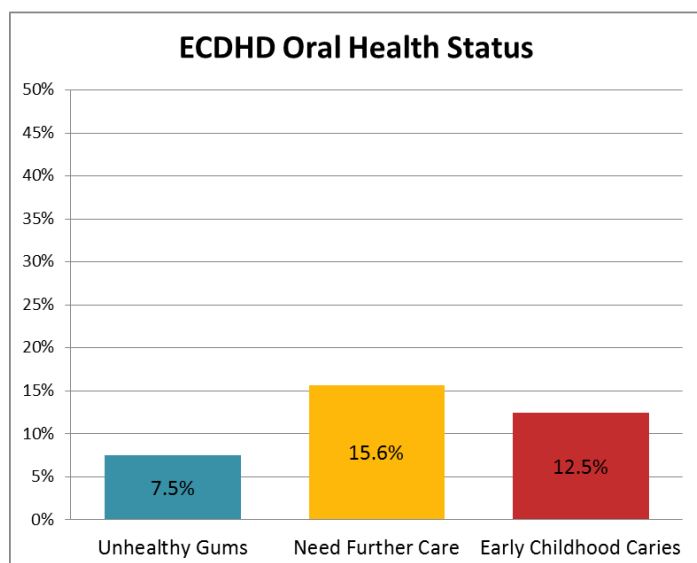
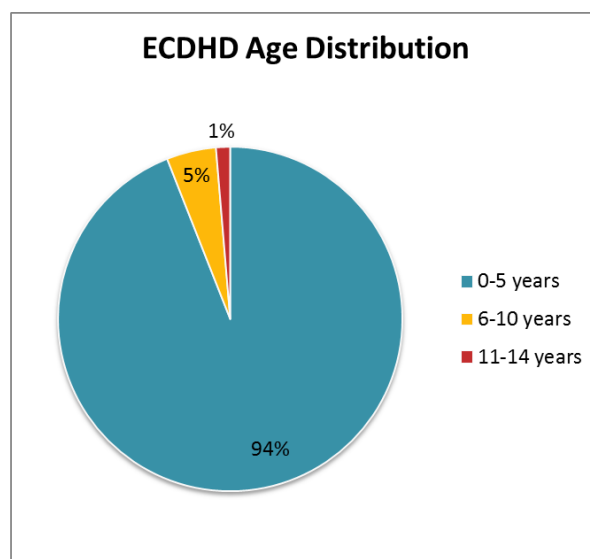
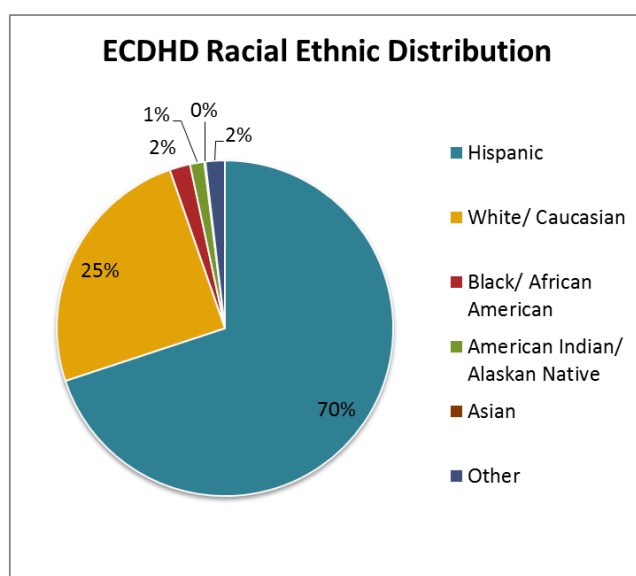
Clinic Hours: **781**

Community Site – WIC: **2**

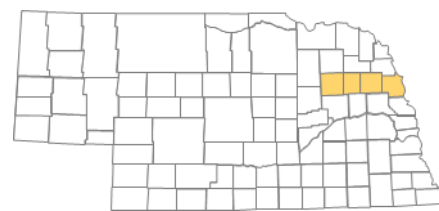
Staff involved with project: **3**

Satisfaction Rate (WIC): **97%**

Intended/Actual Referral Rate (WIC): **92%**



Elkhorn Logan Valley Public Health Department



Population: **59,548**
28.8 People/mi²

Land Area: **2,067.2** mi²
1,654 People/Dentist

Dentists: **36**
57.4 mi²/Dentist

Dental Hygienists: **28**
0.8 RDH/Dentist

Outcomes

Children Seen: **744**

Clinic Hours: **71**

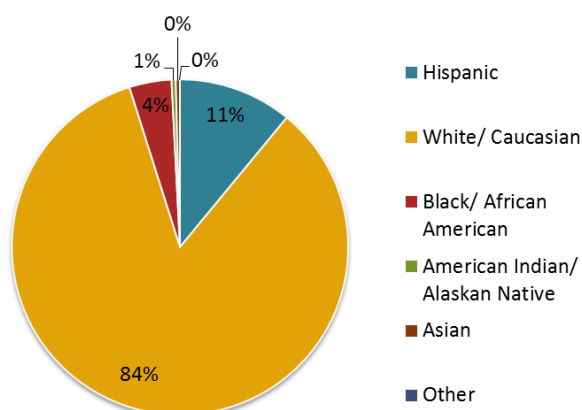
Client Visits: **703**

Community Sites – CC-PS: **3**

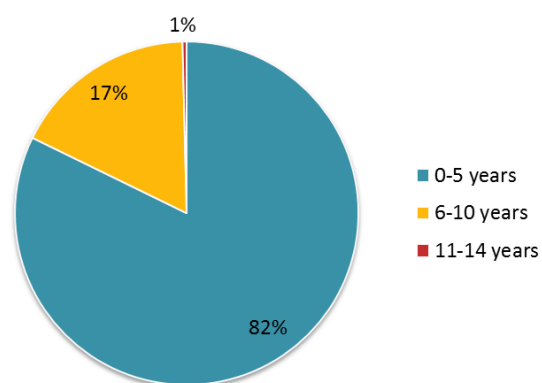
Fluoride Varnish Treatments: **597**

Staff involved with project: **3**

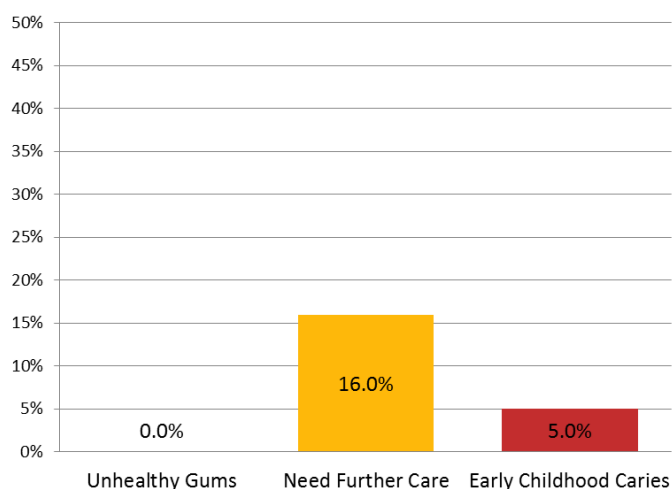
ELVPHD Racial Ethnic Distribution



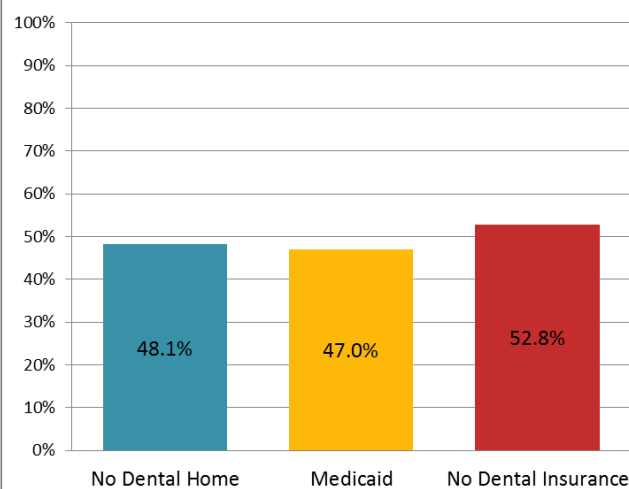
ELVPHD Age Distribution



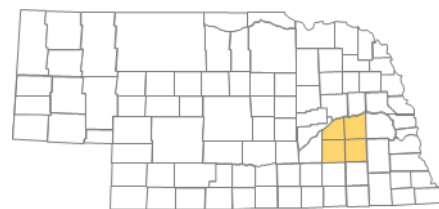
ELVPHD Oral Health Status



ELVPHD Access to Oral Health Care



Four Corners Health Department



Population: **45,105**
20.8 People/mi²

Land Area: **2,172.8** mi²
2,148 People/Dentist

Dentists: **21**
103.5 mi²/Dentist

Dental Hygienists: **21**
1 RDH/Dentist

Outcomes

Children Seen: **245**

Client Visits: **455**

Fluoride Varnish Treatments: **431**

Clinic Hours: **140**

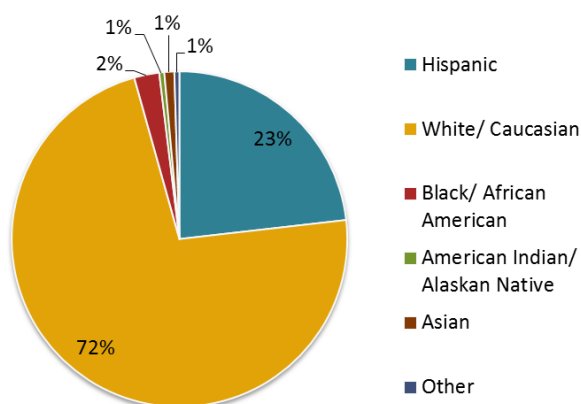
Community Site – WIC: **2**

Staff involved with project: **4**

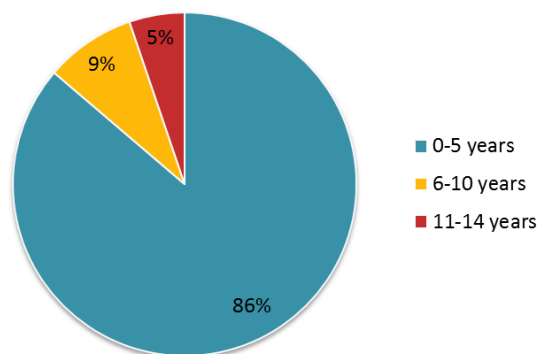
Satisfaction Rate (WIC): **100%**

Intended/Actual Referral Rate (WIC): **98%**

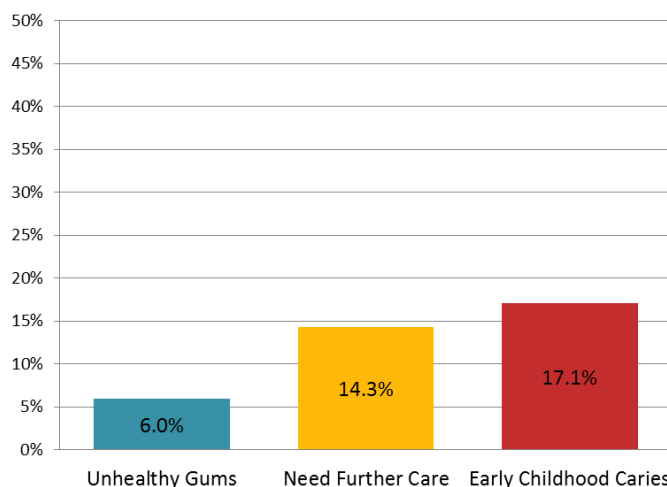
FCHD Racial Ethnic Distribution



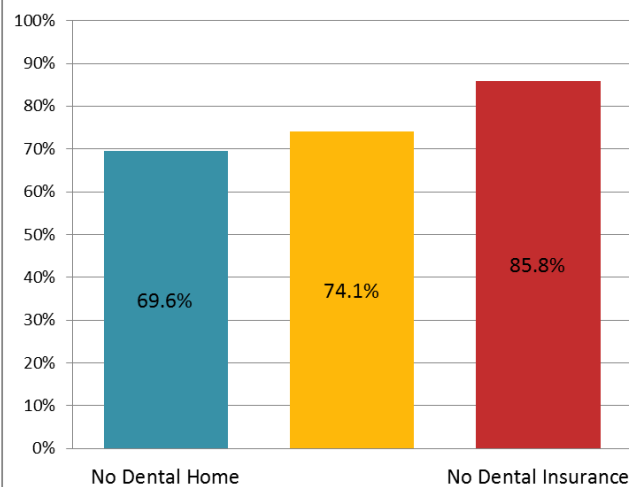
FCHD Age Distribution



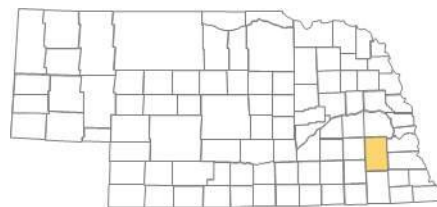
FCHD Oral Health Status



FCHD Access to Oral Health Care



Lincoln-Lancaster County Health Department



Population: **261,545** Land Area: **838.9** mi²
311.8 People/mi² **994** People/Dentist

Dentists: **263**
3.2 mi²/Dentist

Dental Hygienists: **232**
0.9 RDH/Dentist

Outcomes

Children Seen: **404**

Clinic Hours: **82**

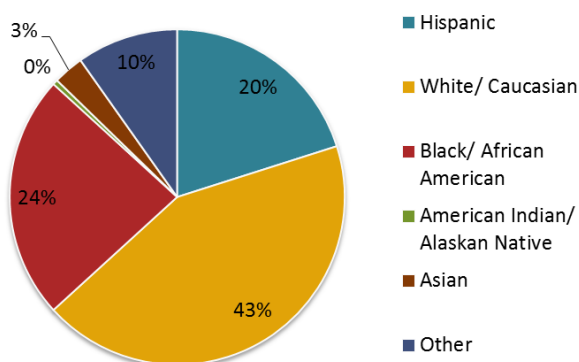
Client Visits: **367**

Community Sites – CC-PS: **3**

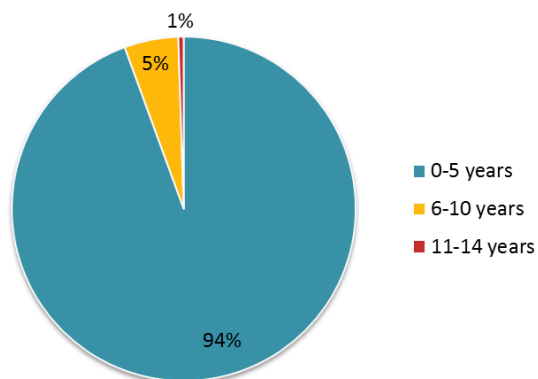
Fluoride Varnish Treatments: **340**

Staff involved with project: **4**

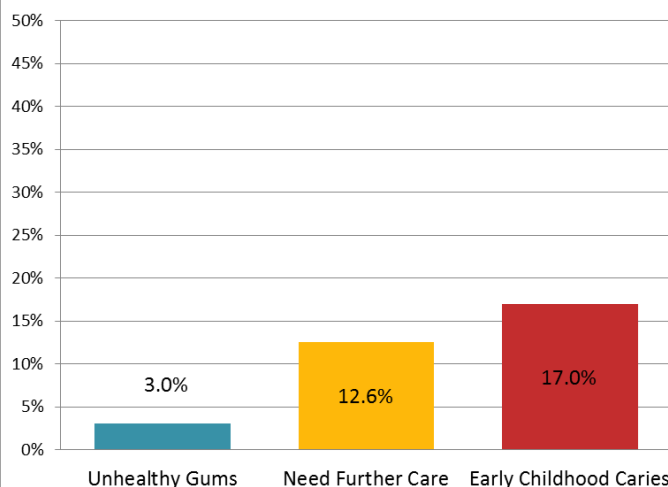
LLCHD Racial Ethnic Distribution



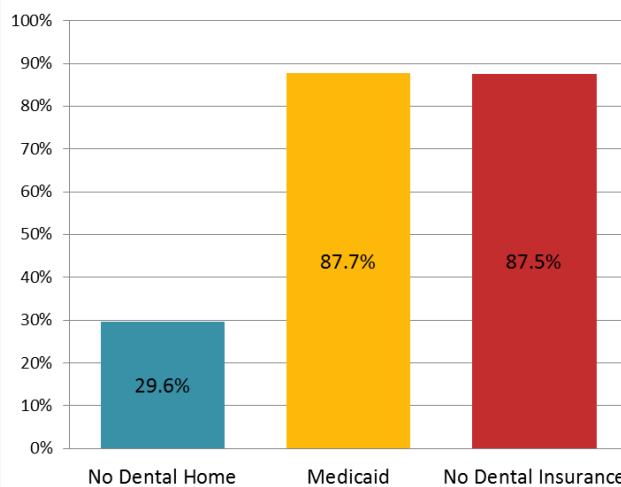
LLCHD Age Distribution



LLCHD Oral Health Status



LLCHD Access to Oral Health Care



Loup Basin Public Health Department



Population: **32,340**
0.4 People/mi²

Land Area: **72,340** mi²
2,940 People/Dentist

Dentists: **11**
6,576.4 mi²/Dentist

Dental Hygienists: **21**
1.9 RDH/Dentist

Outcomes

Children Seen: **906**

Clinic Hours: **67**

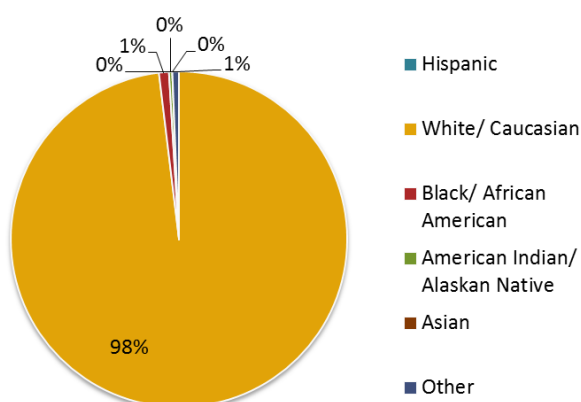
Client Visits: **906**

Community Sites – CC-PS: **8**

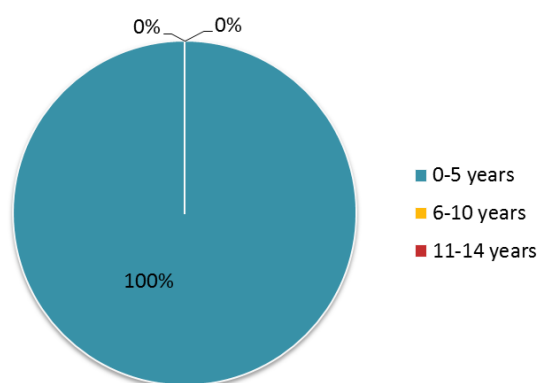
Fluoride Varnish Treatments: **901**

Staff involved with project: **5**

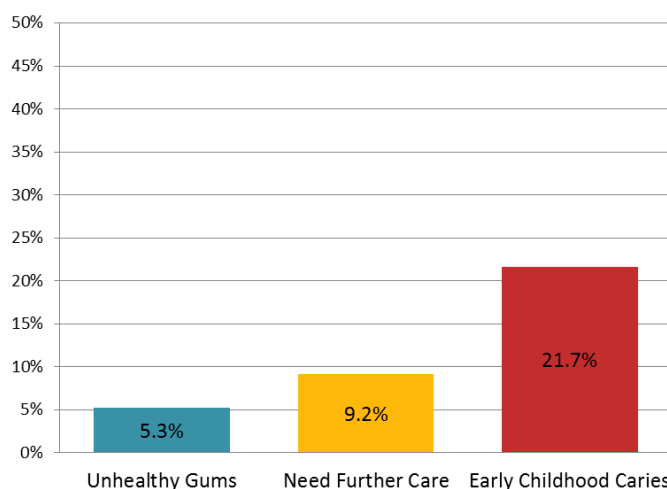
LBPHD Racial Ethnic Distribution



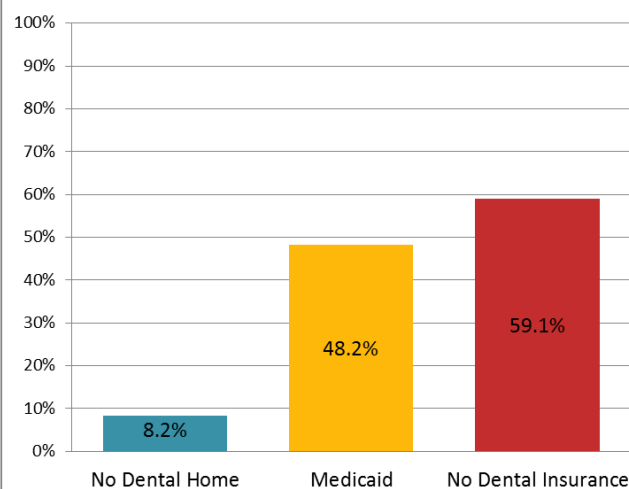
LBPHD Age Distribution



LBPHD Oral Health Status



LBPHD Access to Oral Health Care



North Central District Health Department



Population: **48,941**
3.4 People/mi²

Land Area: **14,455.4** mi²
2,039 People/Dentist

Dentists: **24**
602.3 mi²/Dentist

Dental Hygienists: **30**
1.25 RDH/Dentist

Outcomes

Children Seen: **419**

Client Visits: **610**

Fluoride Varnish Treatments: **587**

Clinic Hours: **185**

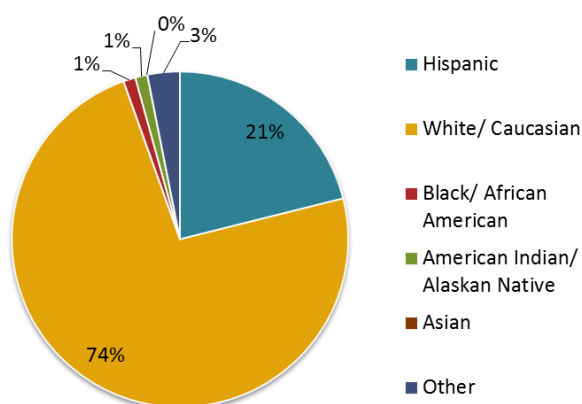
Community Site – WIC: **1**

Staff involved with project: **3**

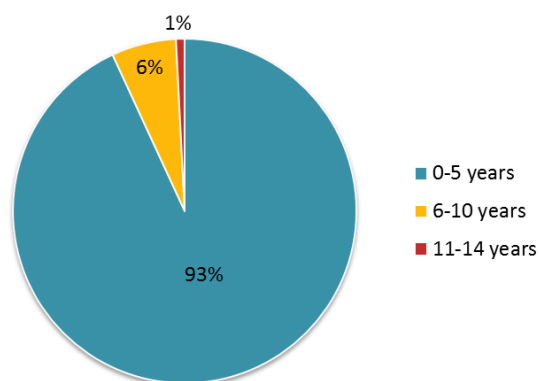
Satisfaction Rate (WIC): **93%**

Intended/Actual Referral Rate (WIC): **95%**

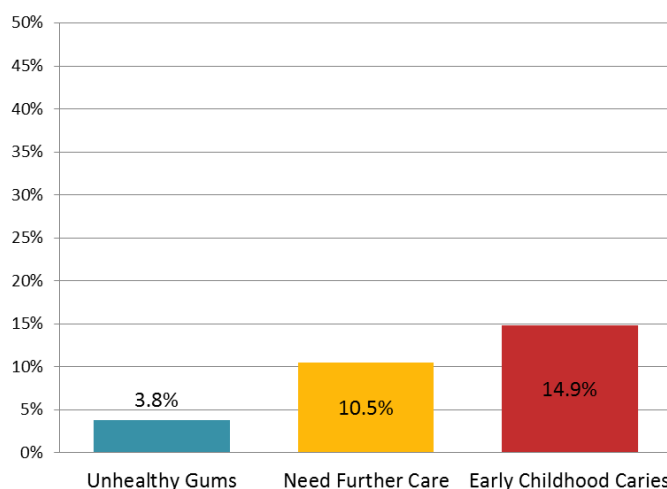
NCDHD Racial Ethnic Distribution



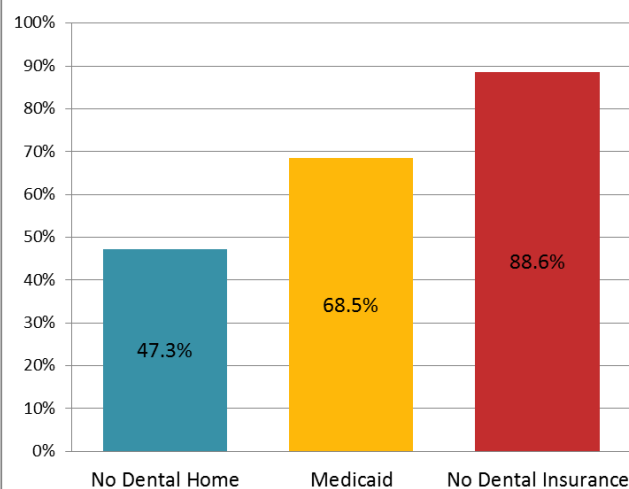
NCDHD Age Distribution



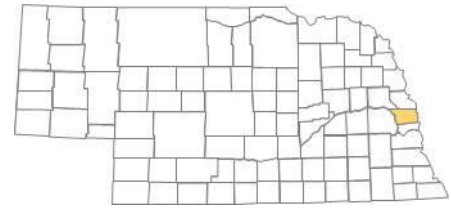
NCDHD Oral Health Status



NCDHD Access to Oral Health Care



One World Community Health Center



Population: **482,112** Land Area: **331 mi²**
1,456.6 People/mi² **1,048** People/Dentist

Dentists: **460**
0.7 mi²/Dentist

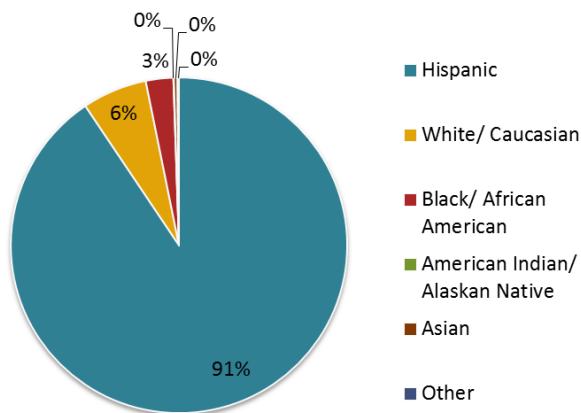
Dental Hygienists: **285**
0.6 RDH/Dentist

Outcomes

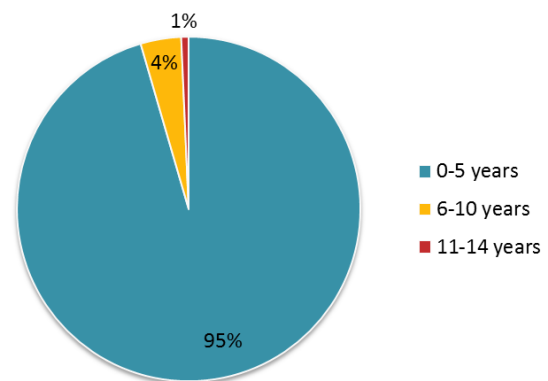
Children Seen: **2,956**
 Client Visits: **3,269**
 Fluoride Varnish Treatments: **3,362**
 Clinic Hours: **960**

Community Site – WIC: **1**
 Staff involved with project: **3**
 Satisfaction Rate (WIC): **95%**
 Intended/Actual Referral Rate (WIC): **95%**

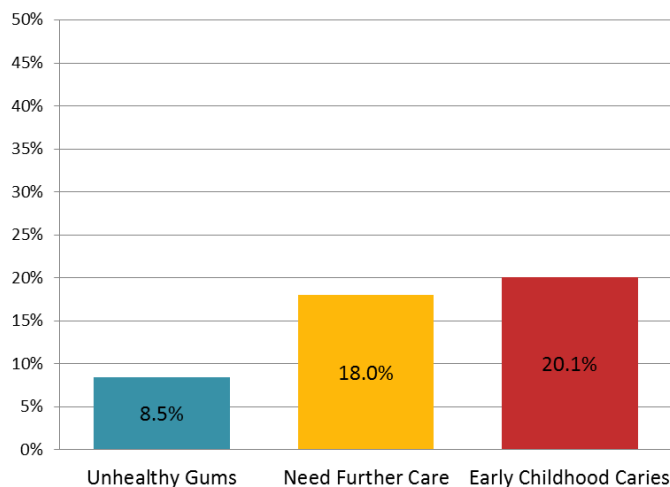
OWCHC Racial Ethnic Distribution



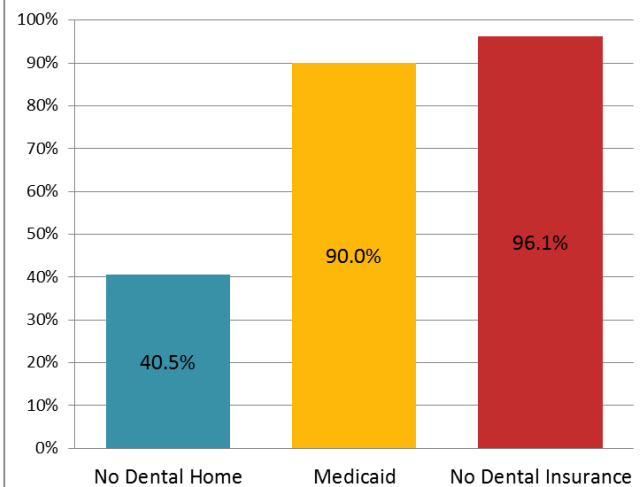
OWCHC Age Distribution



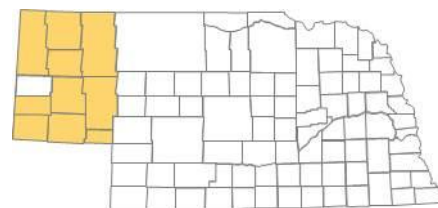
OWCHC Oral Health Status



OWCHC Access to Oral Health Care



Panhandle Public Health District



Population: **87,917**
6.5 People/mi²

Land Area: **13,441.5** mi²
3,663 People/Dentist

Dentists: **24**
560 mi²/Dentist

Dental Hygienists: **26**
1.1 RDH/Dentist

Outcomes

Children Seen: **616**

Client Visits: **909**

Fluoride Varnish Treatments: **885**

Clinic Hours: **363**

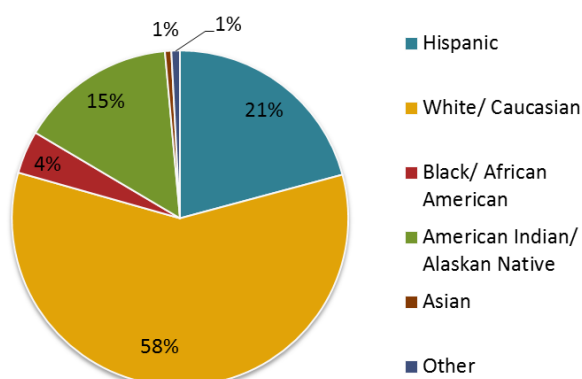
Community Site – WIC: **7**

Staff involved with project: **3**

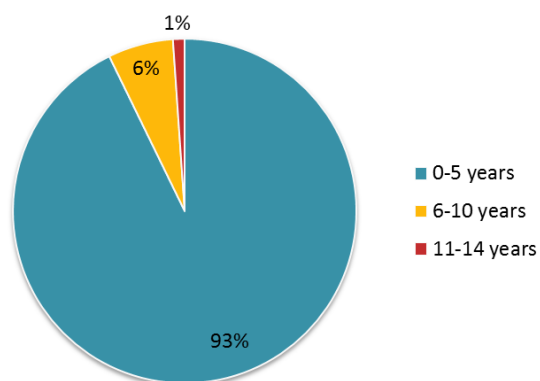
Satisfaction Rate (WIC): **99%**

Intended/Actual Referral Rate (WIC): **99%**

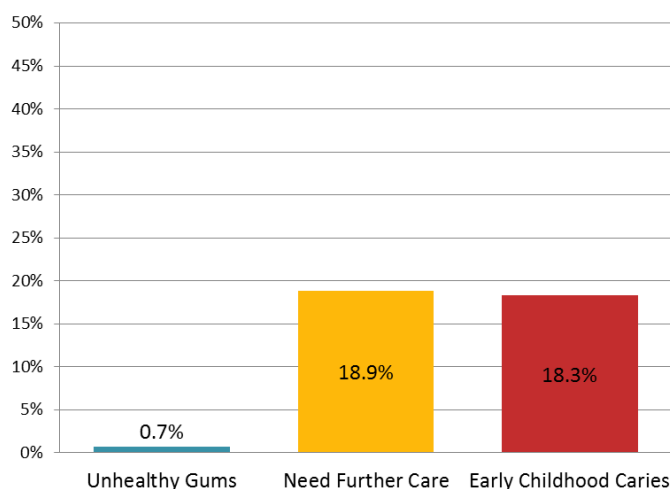
PPHD Racial Ethnic Distribution



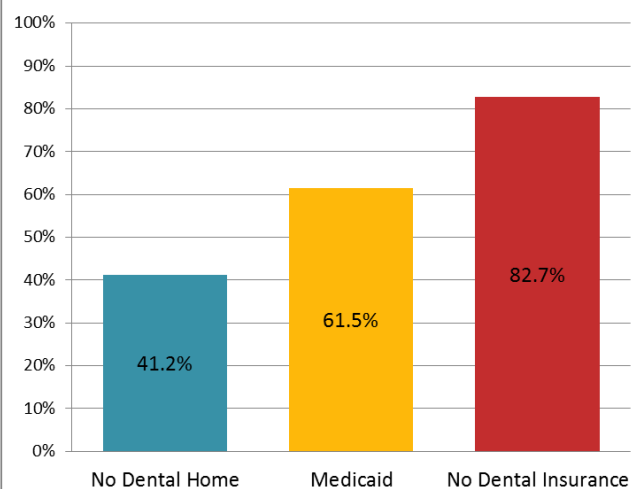
PPHD Age Distribution



PPHD Oral Health Status



PPHD Access to Oral Health Care



Ponca Tribe of Nebraska



Population: **482,112** Land Area: **331 mi²**
1,456.6 People/mi² **1,048 People/Dentist**

Dentists: **460**
0.7 mi²/Dentist

Dental Hygienists: **285**
0.6 RDH/Dentist

Mission:

Outcomes

Children Seen: **140**

Client Visits: **237**

Fluoride Varnish Treatments: **221**

Clinic Hours: **238**

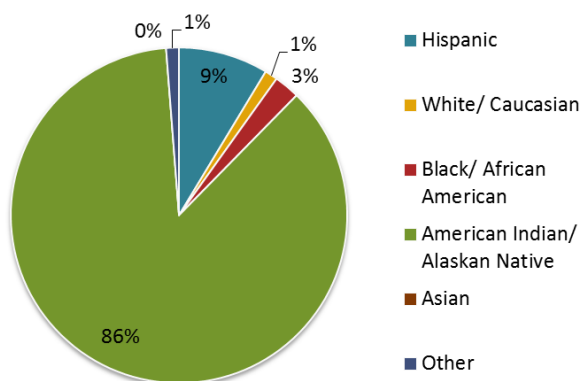
Community Site – WIC: **1**

Staff involved with project: **3**

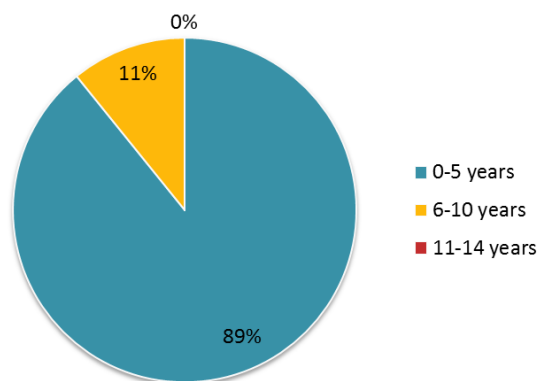
Satisfaction Rate (WIC): **95%**

Intended/Actual Referral Rate (WIC): **99%**

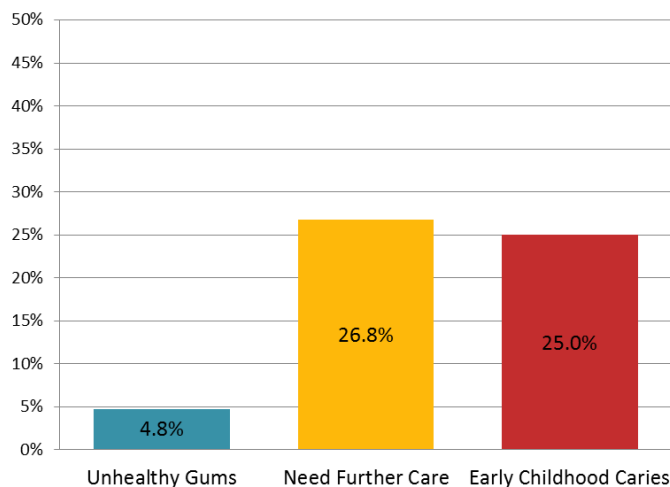
PTN Racial Ethnic Distribution



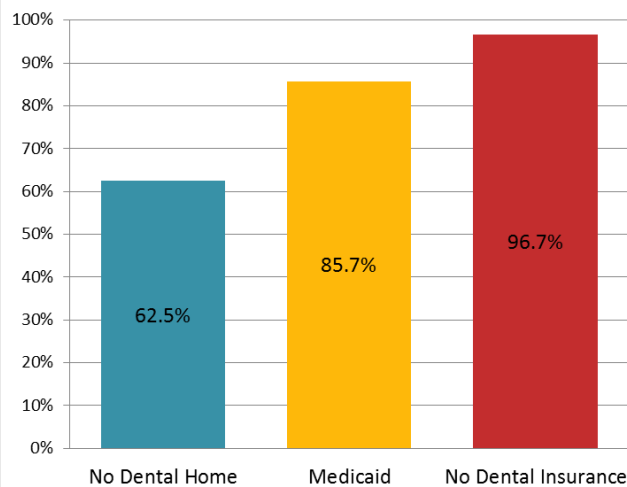
PTN Age Distribution



PTN Oral Health Status



PTN Access to Oral Health Care



Public Health Solutions District Health Department



Population: **57,761**
18.3 People/mi²

Land Area: **3,154.7** mi²
1,925 People/Dentist

Dentists: **30**
105.2 mi²/Dentist

Dental Hygienists: **21**
0.7 RDH/Dentist

Outcomes

Children Seen: **983**

Clinic Hours: **106**

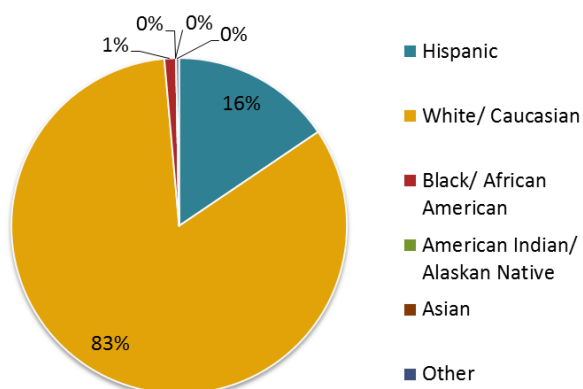
Client Visits: **983**

Community Sites – CC-PS: **7**

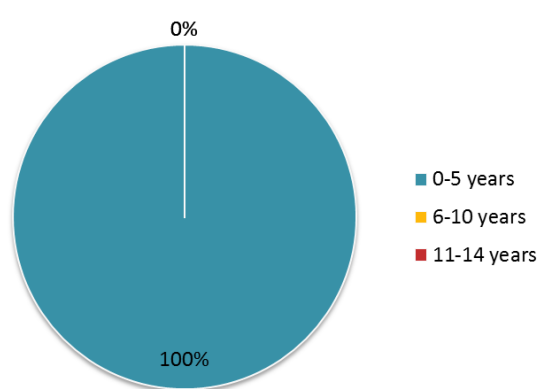
Fluoride Varnish Treatments: **733**

Staff involved with project: **3**

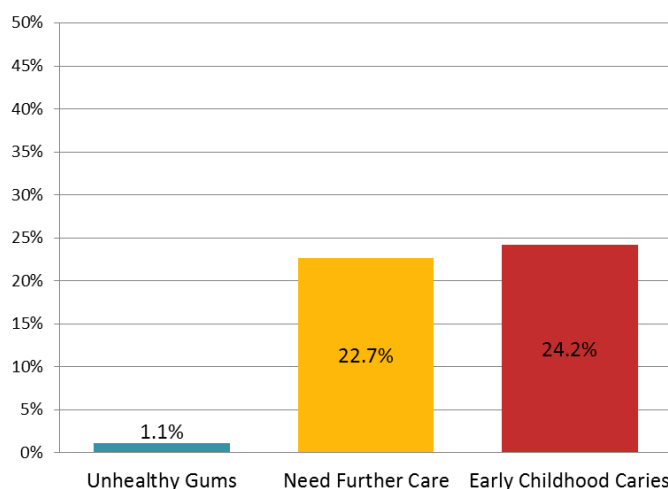
PHSDHD Racial Ethnic Distribution



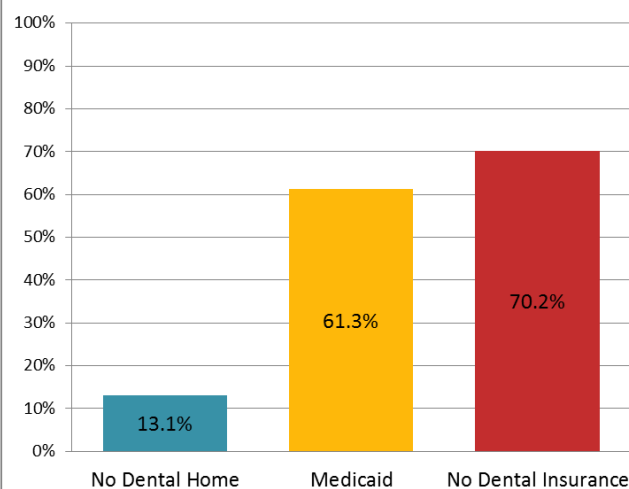
PHSDHD Age Distribution



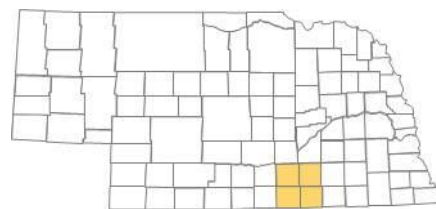
PHSDHD Oral Health Status



PHSDHD Access to Oral Health Care



South Heartland District Health Department



Population: **46,400**
20.3 People/mi²

Land Area: **2,286.6** mi²
1,254 People/Dentist

Dentists: **37**
61.8 mi²/Dentist

Dental Hygienists: **38**
1 RDH/Dentist

Outcomes

Children Seen: **1,713**

Client Visits: **2,380**

Fluoride Varnish Treatments: **2,241**

Clinic Hours: **622**

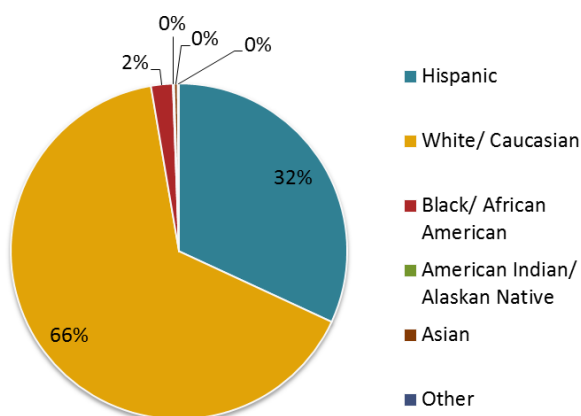
Community Site – WIC: **4**

Staff involved with project: **6**

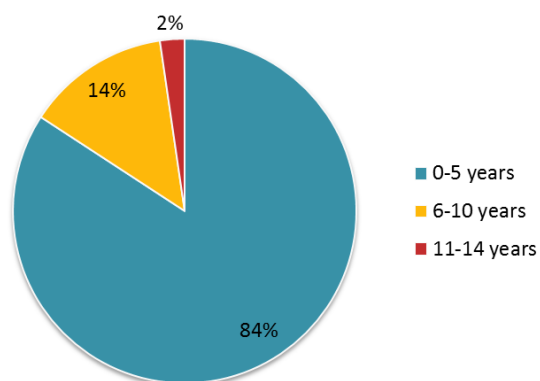
Satisfaction Rate (WIC): **99%**

Intended/Actual Referral Rate (WIC): **99%**

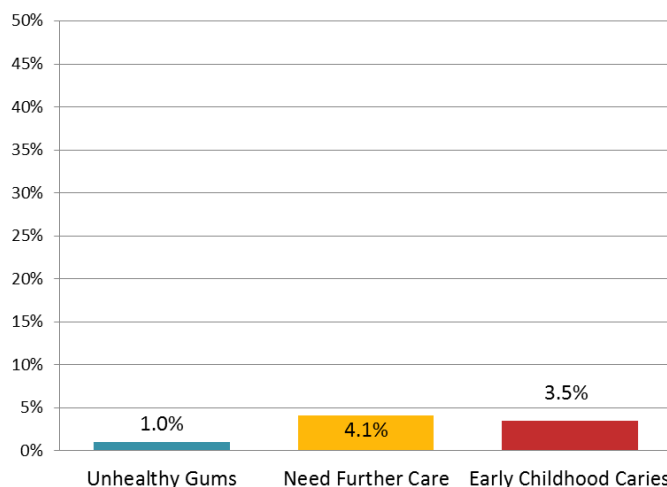
SHDHD Racial Ethnic Distribution



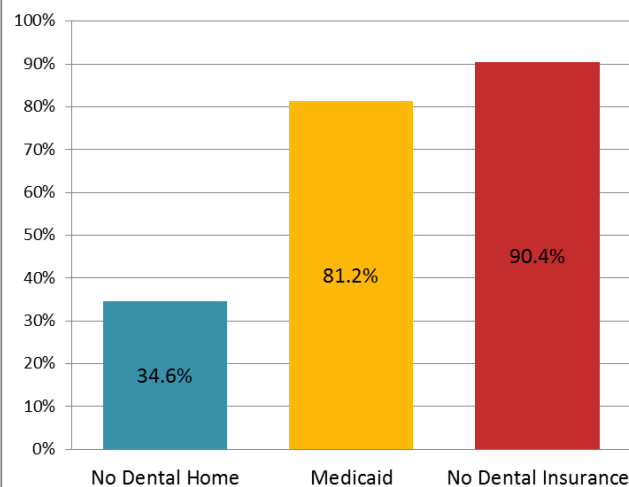
SHDHD Age Distribution



SHDHD Oral Health Status



SHDHD Access to Oral Health Care



Two Rivers Public Health Department



Population: **93,550**
20.2 People/mi²

Land Area: **4,623.8** mi²
1,559 People/Dentist

Dentists: **60**
77 mi²/Dentist

Dental Hygienists: **65**
1.1 RDH/Dentist

Outcomes

Children Seen: **4,146**

Client Visits: **5,425**

Fluoride Varnish Treatments: **5,113**

Clinic Hours: **928**

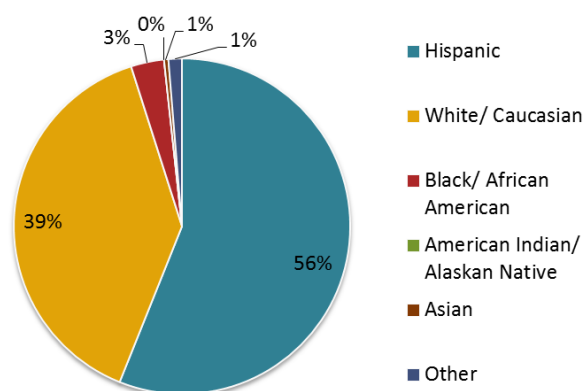
Community Site – WIC: **11**

Staff involved with project: **5**

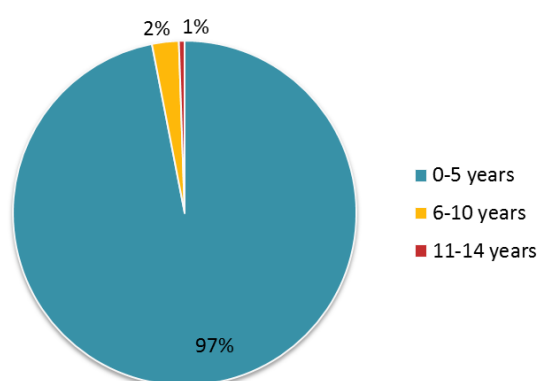
Satisfaction Rate (WIC): **92%**

Intended/Actual Referral Rate (WIC): **93%**

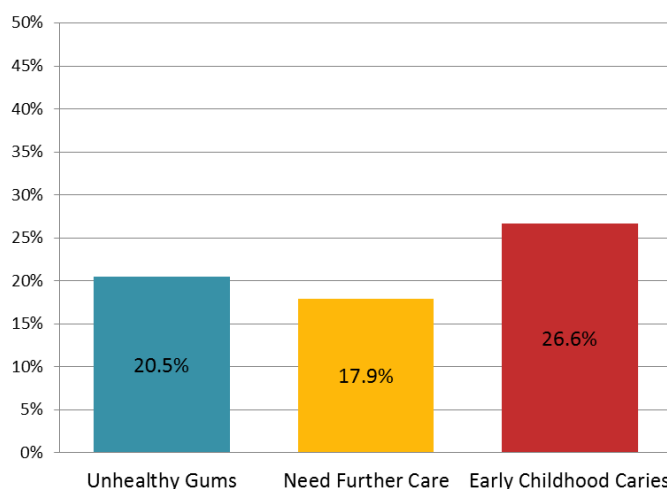
TRPHD Racial Ethnic Distribution



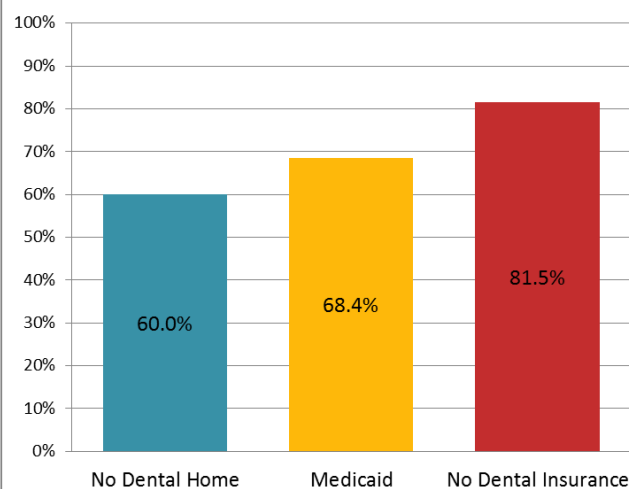
TRPHD Age Distribution



TRPHD Oral Health Status



TRPHD Access to Oral Health Care



West Central District Health Department



Population: **47,077**
11.8 People/mi²

Land Area: **3,993.6** mi²
1,962 People/Dentist

Dentists: **24**
166.4 mi²/Dentist

Dental Hygienists: **25**
1 RDH/Dentist

Outcomes

Children Seen: **436**

Client Visits: **838**

Fluoride Varnish Treatments: **773**

Clinic Hours: **336**

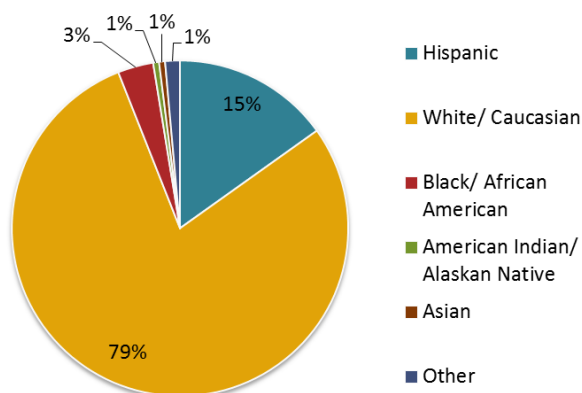
Community Site – WIC: **1**

Staff involved with project: **2**

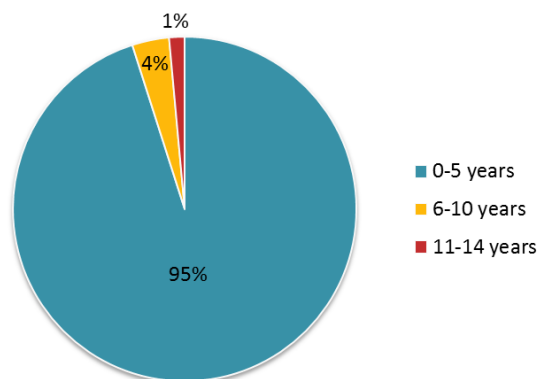
Satisfaction Rate (WIC): **95%**

Intended/Actual Referral Rate (WIC): **98%**

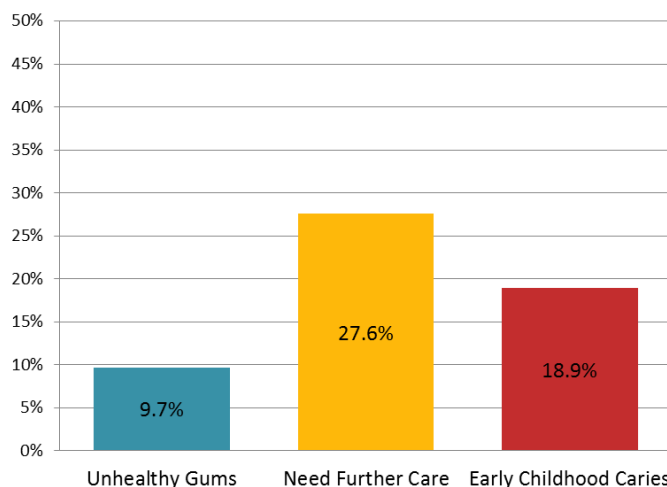
WCDHD Racial Ethnic Distribution



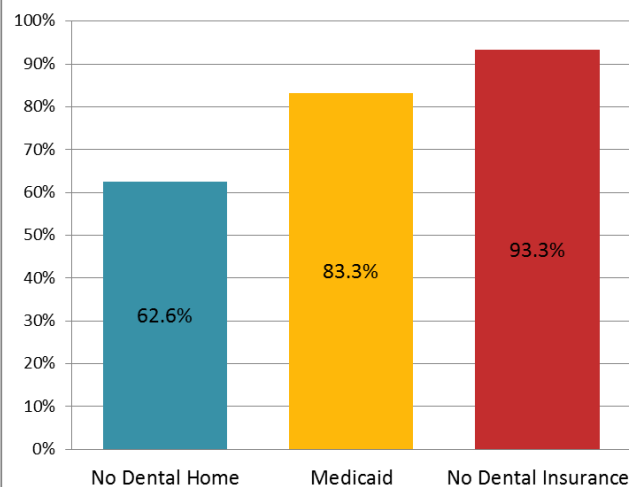
WCDHD Age Distribution



WCDHD Oral Health Status



WCDHD Access to Oral Health Care



Lessons Learned

The Oral Health Access for Young Children program provided dental care to many children in many places throughout Nebraska. Some of the local partners had their own dental clinics; some of them had never had an oral health program before. Some of the partners were in cities and visited by many families; others were in small rural towns where families came as they were able. Differing program settings and capacities made providing services easier for some and more difficult for others. Below are some of the strengths and challenges of the OHAYC program identified by local partners.

Strengths

Consistent Community Presence

The OHAYC program provided dental care through working partnerships with existing community organizations. This made the program very accessible for families that were already involved in WIC clinics, Head Start programs, or child care.

Home Care and Prevention

Families involved in the OHAYC program received more than a check-up and fluoride treatment – they also received toothbrushes and toothpaste to take home with them, as well as education on their proper use.

Supportive Partnerships with Host Site

The WIC, Head Start, and child care host sites provided a lot of support. In addition to providing a place for dental hygienists to work, many of them also helped promote OHAYC to the families involved in their programs through flyers, reminder phone calls, and by directing parents to the fluoride varnish program on the days they were present in the clinic.

*“What worked well was being **available in the community**. Consistently being there and giving advice, fluoride treatments, and toothbrushes with paste. We had more and more return visits with participants having questions or concerns, or just wanting to keep their children up on the fluoride treatments.” CDCHC*

*“If the children did have a dental problem the parents were made aware of the problem and **early action** could be taken to make sure that the problem did not worsen.” ELVPHD*

Involving Families in Children's Dental Care

Being situated in family-based organizations made it easy for OHAYC staff to communicate with the families of the children they served, and to involve parents and guardians in their care. In WIC clinics, families were often on-site; in Head Start and child care settings, the staff of the host site had established relationships with families which OHAYC was able to build on.

Repeat Visits

In many of the OHAYC clinics, children were able to receive dental care multiple times thanks to effective promotion of the program, its accessibility within the community, and education by program staff about the importance of oral health and the benefits of repeated fluoride application.

Dental Clinic Provides Effective Referral Options

For programs working in partnership with a dental clinic, it was easy to refer children to a dentist for restorative or follow-up care. Sometimes a dentist was available at the same site where the program took place.

Flexible Program Model Allows Programs to Grow

Because the OHAYC program was designed to be administered by local programs to conduct work in community settings (see Appendix A on page 29), local partners were able to determine the best sites for programs to take place, and make changes if necessary. For example, if one site had consistent scheduling conflicts that prevented services from being delivered, it could be removed from the program. On the other hand, if there was a high need for services in a community without an OHAYC program, one could easily be added.

“We were able to cover several locations of WIC and Head Start programs in the northern panhandle. There was **obvious need** for treatment and we were able to complete it on site in both settings.” PPHD

“This program is **extremely vital** to our community... For some of the families that we saw, this was the **only dental care that they could afford** to get.” WCDHD

Met an Identified Community Need

The OHAYC program provided needed dental screening, care and referral to children and families who needed it most.

Challenges

Need for Referral Options in Settings without a Dental Clinic

The dental services provided in the OHAYC program were preventive – basic screenings, fluoride varnish applications, and referrals for additional care. Many of the programs that did not have immediate access to a dental clinic had significant difficulties connecting children needing advanced restorative care with local dental providers.

“The **greatest challenge** to serving children 0-5, is finding dental providers who are willing to accept Medicaid as well as families without dental insurance.” CDHD

“We continue to **struggle with referral** for restorative needs.” TRPHD

“Unfortunately, it is still **difficult to get local dentists** to see Medicaid patients and often times getting to a dentist in another location causes barriers with transportation, etc.” PHSDHD

Staff Turnover / Unavailability

Because each program typically had a small number of staff qualified to carry out the program, OHAYC clinics sometimes had to be canceled or rescheduled due to staff turnover, illness or poor travel conditions.

Coordinating Schedules and Staff with Host Site

Occasionally, working around the events and activities presented a challenge for OHAYC programs. In addition, because some OHAYC clinics happened infrequently, families sometimes had difficulty scheduling their appointments for the next available clinic date.

Children with Dental Anxiety

*“The more that the children with previous signs of dental anxiety came in ... the more their **anxiety decreased** and positive dental behaviors were established.” WCDHD*

Some children were uncomfortable with or afraid of the oral exam and fluoride varnish treatment. OHAYC staff worked with the children and their families to familiarize them with the process by allowing them to touch the disposable brushes, or to watch other children being treated. Children who refused an exam could still receive dental care packets, and many of

them became more comfortable with the process as time went on.

Reporting Structure

The reports created for the OHAYC program were designed to gather outcomes information monthly, and process information twice per year. The amount and frequency of paperwork became burdensome and time consuming for several of the programs, especially those that saw many kids. Some programs expressed frustration at not having access to equipment that would allow for more thorough screening and more complete reporting.

Differences in Methods

The exam and treatment process the programs followed included a procedure that many of the dental hygienists had not used before – the use of iodine to clean the tooth surface prior to the fluoride varnish application. Although dental research exists that supports the procedure, several of the programs remained unconvinced about its inclusion in this particular program.

*“**Cultural differences** in our community present barriers.” CDHD*

Cultural and Language Differences

Many of the OHAYC clinics served families of diverse cultural backgrounds who brought practices, beliefs, and languages that some of the programs felt unequipped to fully address. Although programs were equipped with interpreters, many of them were only English-Spanish bilingual, leaving other immigrant and refugee groups without the benefit of interpretation services.

Partnerships

OHAYC Connected Children and Families to:

Local Dentists

“We made early referrals so that the children could be treated with a better experience in a **local dentist office** vs. having to undergo surgical intervention.” PHSDHD

“Dental Home Referral linkages were established/ maintained with **UNMC Pediatric Dental Clinic**, a private practice **dentist**, and **Ponca Dental Clinic**.” PTN

Federally Qualified Health Centers and Public Health Care Facilities

“We have had referrals to and from the [Maternal Child Health] **immunization clinic**.” ECDHD

“Clients were informed of not only the local dental providers but of the services at **UNMC College of Dentistry** in Lincoln and **Good Neighbor Community Health Center** in Columbus.” FCHD

State and Community Dental Programs

“We were able to help encourage people to get the additional care needed through **Dental Day**, **Mission of Mercy** and other local resources such as the **CAPWN clinic**. This also provided a means to check to see if there had been follow through.” PPHD

OHAYC Connected Local Programs to:

Host Sites – WIC, Head Start, Preschool and Daycare

“We conducted parent educational meetings with the Public Health Dental Hygienist serving as the guest presenter” in the **preschool / daycare** setting. ELVPHD

“We have shared information about this program with the area **Head Start** providers and several larger **daycare** providers, and presented this program at various events for children and families.” FCHD

“Our relationship with **WIC** has never been stronger and we share common goals.” ECDHD

“Relationships have been built with **pre-school**, **Head Start**, and **Early Head Start** staff, **Community Action Agency** staff, **dentists**, and **hygienists**.” LBPHD

Community Organizations

“A strong partnership between **North Central District Health Department** and **Central Nebraska Community Services** – WIC program developed as a result of the program, as well as partnering with the **Public Health Outreach Nursing Education (PHONE)** program at the health department in order to assist families with establishing a dental home.” NCDHD

SHDHD has had a long-standing partnership with **Central Community College-Hastings Dental Hygiene program** – and this partnership has been maintained and deepened with the Oral Health Access project. SHDHD

Nebraska Department of Health and Human Services

“We look forward to future collaborative opportunities and projects.” LLCHD

“We enjoyed the opportunity to work with the **Office of Oral Health and Dentistry**. The resources, training, and conference calls were informative and assisted us in improving our program.” LBPHD

*“A positive outcome of this program was the **connections** established with the State of Nebraska’s **Oral Health and Dentistry** personnel and others **throughout the State** who had an interest in the oral health and wellness of children and families in Nebraska.” NCDHD*

Continued Connections:

The Oral Health Access for Young Children program established, strengthened and deepened purposeful partnerships at the state, local, and community levels. In some cases, these partnerships built on existing community infrastructure. In others, they laid the foundation for future working relationships. Many of the programs intend to continue developing and expanding on these partnerships even after the end of OHAYC funding. Here are some exciting examples:

*“Our hopes were to continue and grow into the schools and begin a **school based sealant program**. We will still be working to accomplish this but it will take more time with the loss of funding.” PHSDHD*

“Daily tooth brushing policies have been established at the two remaining childcare centers that are participating in the project. This **environmental change** at both centers will benefit children for years to come. Establishing these **policies** we feel is one of the biggest accomplishments of this project.” ELVPHD

“The data collected, showing that through July, approximately 20.6 % of program participants did not have a dental home. This provides us with a **community snap shot** and some **base line data** to work toward assuring **access to dental homes** with WIC, Head Start and Early Head Start children.” LLCHD

“Adolescent health, including Oral Health is a priority for the Health Department and this program may complement other **health promotion opportunities** in the future for youth.” LBPHD

“North Central District Health Department credits implementing Oral Health Access for Young Children program as the beginning point to **take action** towards providing oral health preventative services to **meet the needs of children and their families** in the health district.” NCDHD

“Central District Health Department in partnership with Third City Community Clinic and St. Francis Medical Center are providing **continuation funding with a reduction in services** for a period of 1 year. The hope is that funding opportunities can be found at the local, state or national levels to allow the successes we have attained to be sustained.” CDHD

“We plan to **continue the program** and model it after the ‘Program in a Box’ [OHAYC].” PTN

“In continued partnership, SHDHD and CCC are going ahead to **pilot a program** that will provide **sealants in 2 elementary schools** this year, using funding and supplies secured by the hygiene program.” SHDHD

“We have been able to secure funding to **continue and expand** our program through DHHS MCH funding and are looking forward to continuing to provide and grow this program for the next two years.” TRPHD

“The **enhanced community partnerships**, collaboration, and public health exposure continue to facilitate an **increased awareness and importance** of dental health among community partners and participants.” LLCHD

Missed Connections:

Although OHAYC partnerships built community-level infrastructure, strengthened working relationships and provided needed access to oral health care to children and families across the state, not all of them could be self-sustaining after only a year and a half. From its beginning in January 2011 to the end of funding in August 2012, the OHAYC program built momentum and inspired innovative ideas to increase access to Nebraskans in need of oral care. Here are some examples of the impact of the loss of funding on a growing program:

“The project was just **beginning to become established** locally.” CDHD

“We are sorry to see it end, as we feel we were **making an impact** on reducing ECC.” ECDHD

“Chadron Job Corp was very interested... but we were **not able to serve them...** In our last proposal, which was not funded... we had an **overwhelming interest** from area schools ...” PPHD

“This program offered a **much needed service** to these families. **Inroads were made...** we fear that many will again go without needed oral health education and services.” FCHD

Conclusion

Recommendations

The Oral Health Access for Young Children program provided needed oral health care to children and families in Nebraska through the committed work of state, local and community-level partners. Based on lessons learned through the implementation of OHAYC, future versions of the program could benefit from:

A Simplified Reporting System

Recommend quarterly rather than monthly reporting.

A Formalized Communication Plan

Recommend a quarterly conference call at minimum.

Expanded Services and Partnerships

Recommend adding sealants to program services and expanding to additional community settings.

*“Coordination of a strong state-based public health program is **critical** to achieve optimal oral health, **especially** to those underserved.” CDHD*

*“We can make a **big impact** with very little monetary cost.” PTN*

Opportunities

The OHAYC program did more than provide oral health screening, care and referrals to thousands of children across Nebraska. It also sheds a light on some of the significant needs of families struggling to access oral health care and services in our state.

Need for Increased Oral Health Education

Local programs reported that many parents were not aware of some very basic oral health concepts or of the importance of prevention. Increasing oral health knowledge, influencing beliefs about oral health, and equipping parents and guardians to establish preventive oral health habits in the home should be a priority of community-based public health programs.

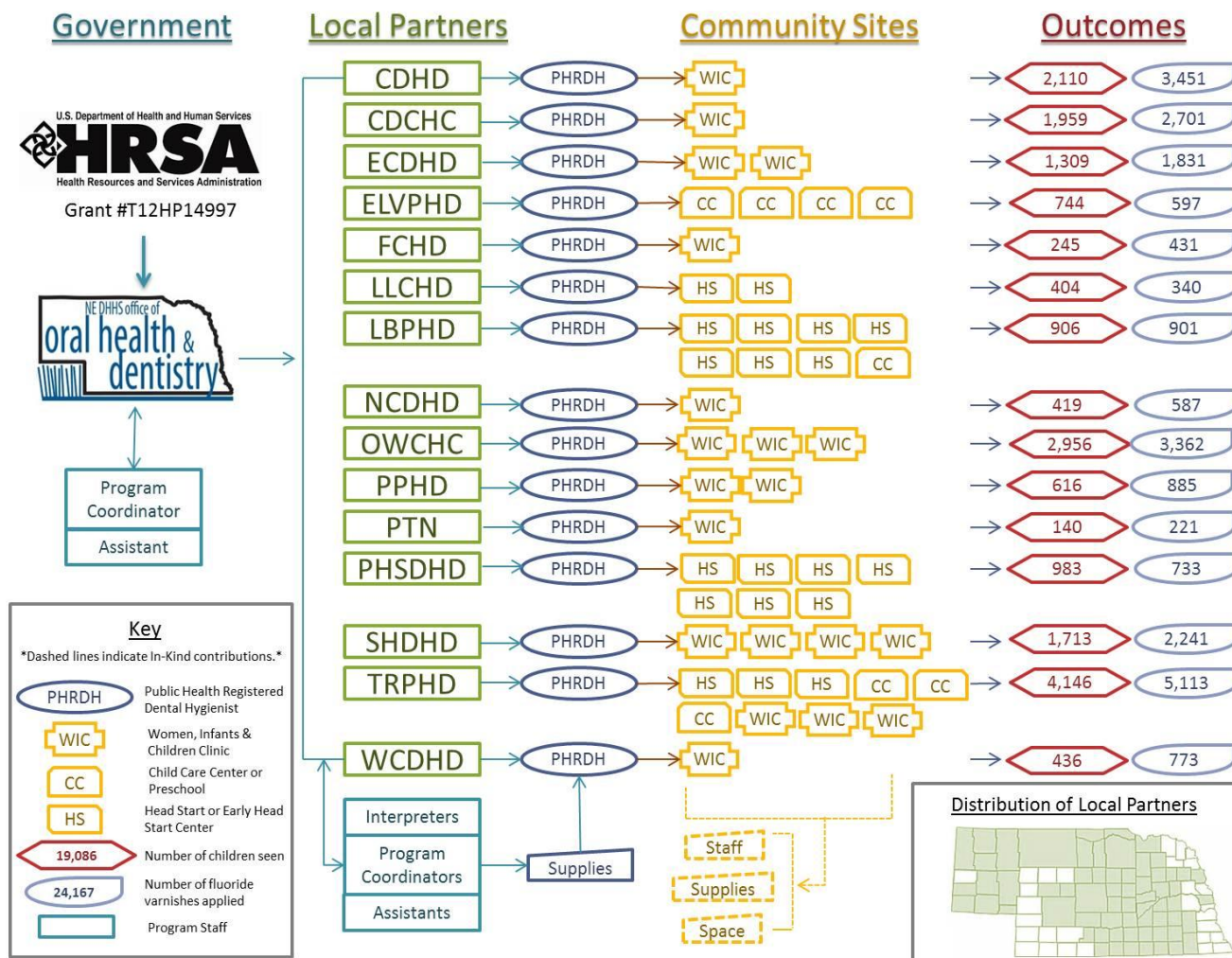
Need Increased Cultural Competence in Oral Health Care and Oral Health Literacy

Efforts should be made to minimize the social barriers that reduce access to oral health care in the community. These barriers include differences between patients and providers in language, literacy, customs, and/or beliefs that result in underutilization of available services and poor oral health.

Need for More Accessible Oral Health Providers and Programs

While oral health providers and programs exist across the state, they can be inaccessible for some families due to distance, inadequate insurance, or limited availability. These barriers can be addressed by the OHAYC model of building community infrastructure, developing interdisciplinary partnerships, and increasing opportunities for community-level oral health care.

January 2011-August 2012



Appendix B – OHAYC Forms

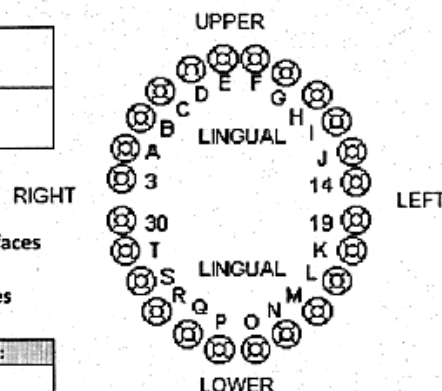
Dental Screening Form

Pediatric Oral Health Screening Form

Preschool/Head Start Setting



Patient Name:	
Screen Date:	Site:
Therapist's Initials:	Age:
Race/Ethnicity:	
<input type="checkbox"/> White/Caucasian <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> African American/Black <input type="checkbox"/> Other	



Treatment Urgency:	Early Childhood Caries:	White Lesions:	Gingival Health:
<input type="checkbox"/> No Obvious Problems <input type="checkbox"/> Early Dental Care <input type="checkbox"/> Urgent Care	<input type="checkbox"/> No ECC <input type="checkbox"/> ECC <input type="checkbox"/> S-ECC	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Healthy <input type="checkbox"/> Not Healthy

Treatment:	Dental Home	Medicaid	Dental Insurance	Note Sent Home:
<input type="checkbox"/> Iodine <input type="checkbox"/> FI Varnish <input type="checkbox"/> Exam	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

Comments:

ECC = One or more decayed, missing (due to caries) or filled surfaces in any primary tooth in a child 71 months of age or younger.
 S-ECC = Any sign of smooth-surface caries is considered severe early childhood caries in children younger than 3 years of age.

Date:	Therapist's Initials:	Age:	Treatment:	Gingival Health:	Treatment Urgency:	Recommended TX Completed:	Note Sent Home:
			<input type="checkbox"/> Iodine <input type="checkbox"/> Exam <input type="checkbox"/> FI Varnish	<input type="checkbox"/> Healthy <input type="checkbox"/> Not Healthy	<input type="checkbox"/> No Obvious Problems <input type="checkbox"/> Early Dental Care <input type="checkbox"/> Urgent Care	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> In Progress	<input type="checkbox"/> No <input type="checkbox"/> Yes
Comments:							

Date:	Therapist's Initials:	Age:	Treatment:	Gingival Health:	Treatment Urgency:	Recommended TX Completed:	Note Sent Home:
			<input type="checkbox"/> Iodine <input type="checkbox"/> Exam <input type="checkbox"/> FI Varnish	<input type="checkbox"/> Healthy <input type="checkbox"/> Not Healthy	<input type="checkbox"/> No Obvious Problems <input type="checkbox"/> Early Dental Care <input type="checkbox"/> Urgent Care	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> In Progress	<input type="checkbox"/> No <input type="checkbox"/> Yes
Comments:							

Date:	Therapist's Initials:	Age:	Treatment:	Gingival Health:	Treatment Urgency:	Recommended TX Completed:	Note Sent Home:
			<input type="checkbox"/> Iodine <input type="checkbox"/> Exam <input type="checkbox"/> FI Varnish	<input type="checkbox"/> Healthy <input type="checkbox"/> Not Healthy	<input type="checkbox"/> No Obvious Problems <input type="checkbox"/> Early Dental Care <input type="checkbox"/> Urgent Care	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> In Progress	<input type="checkbox"/> No <input type="checkbox"/> Yes
Comments:							

Monthly Report Form



Oral Health Access for Young Children Monthly Report

Directions: Please complete this report and submit it to Nebraska Office of Oral Health and Dentistry, dhhs.oralhealth@nebraska.gov or 402-471-6446 (fax) on the 1st of each month. For WIC programs, use one form for each program location.

Date: _____

Name of person completing report: _____

Organization name: _____

Monthly Summary Report: Please calculate data from the program log and list monthly totals below:

Location of Program: _____

Address: _____

Circle one: WIC Head Start Early Head Start Preschool/Child Care

List all dates the program was offered this month and available treatment hours for each day (example: January 31 (5 hours); February 7 (6 hours):

Number of pediatric patients seen by age range at this location this month:

0-1

2-3

4-5

6-8

9-13

Total number patients age 14 and over seen at this location this month:

Total number of fluoride varnish treatments given at this location this month:

Comments or Notes:

Annual Report Form



Oral Health Access for Young Children Annual Report

September 1, 2011-August 31, 2012

Directions: Please complete this report and submit it to Nebraska Office of Oral Health and Dentistry, dhhs.oralhealth@nebraska.gov or 402-471-6446 (fax) at the end of the grant period. Please use one form for each program location.

Date: _____

Name of person completing report: _____

Organization name: _____

Annual Summary Report: Please calculate data from the program log and list end-of-the-year totals below:

Location of Program: _____

Circle one: WIC Head Start Early Head Start Preschool/Child care

Number of pediatric patients seen by age range:

0-1 2-3 4-5 6-8 9-13

Total number of pediatric patients seen at this location:

Total number of adult patients seen at this location:

Total number of fluoride varnish treatments given at this location:

Total number of initial patient visits:

Total number of second patient visits:



Total number of third patient visits:

Total number of fourth patient visits:



Comments:

Parent Satisfaction Survey

Oral Health Access for Young Children Parent/Guardian Survey		Location: _____	Date: _____
Instructions: Select (x) one response for each question.			
1. How confident are you that you can prevent cavities in your child's teeth? <input type="checkbox"/> Very confident <input type="checkbox"/> Confident <input type="checkbox"/> Neutral <input type="checkbox"/> Not Confident <input type="checkbox"/> Not at all confident			
2. How would you rate your overall level of satisfaction with the service you and your child received? <input type="checkbox"/> Very satisfied <input type="checkbox"/> Satisfied <input type="checkbox"/> Neutral <input type="checkbox"/> Dissatisfied <input type="checkbox"/> Very Dissatisfied			
3. How likely are you to refer others to this program? <input type="checkbox"/> Likely <input type="checkbox"/> Unlikely <input type="checkbox"/> I have already referred others to this program			
TO BE FILLED OUT BY DENTAL TEAM STAFF			
4. Ages of children seen today. (List Ages) _____			
5. Do you take your children to a dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not All Children (Specify) _____			
6. Do you take your children to the same dentist for return visits? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not All (Specify) _____			
<small>This publication was made possible by Grant Number T12HP14997 from Health Resources and Services Administration (HRSA)</small>			



VISIT:
☐ 1ST ☐ 5TH
☐ 2ND ☐ 6TH
☐ 3RD ☐ 7TH
☐ 4TH ☐ 8TH

Encuesta para los Padres/Guardianes de Niños con Acceso a Salud Oral		Localidad: _____	Fecha: _____
Instrucciones: Marque cada respuesta con una (x).			
1. ¿Qué tan seguro está usted de que puede prevenir las caries en los dientes de su niño? <input type="checkbox"/> Muy Seguro <input type="checkbox"/> Seguro <input type="checkbox"/> Neutral <input type="checkbox"/> Inseguro <input type="checkbox"/> Muy Inseguro			
2. ¿Cómo calificaría su nivel de satisfacción con el servicio que usted y su niño recibieron? <input type="checkbox"/> Muy Satisfecho <input type="checkbox"/> Satisfecho <input type="checkbox"/> Neutral <input type="checkbox"/> Insatisfecho <input type="checkbox"/> Muy Insatisfecho			
3. ¿Cual es la posibilidad de que usted refiera a otra persona a este programa? <input type="checkbox"/> Probable <input type="checkbox"/> Improbable <input type="checkbox"/> Ya he referido a otra persona a este programa			
ESTA PARTE ES LLENADA POR LOS EMPLEADOS DEL EQUIPO DENTAL			
4. Edades de los niños vistos hoy: (Liste las edades) _____			
5. ¿Lleva usted a sus niños al dentista? <input type="checkbox"/> Si <input type="checkbox"/> No <input type="checkbox"/> No Todos (Especifique) _____			
6. ¿Lleva usted a sus niños al mismo dentista para todas las visitas? <input type="checkbox"/> Si <input type="checkbox"/> No <input type="checkbox"/> No Todas (Especifique) _____			
<small>Esta publicación ha sido posible gracias al Numero De Subvención T12HP14997 de parte de Health Resources and Services Administration (HRSA).</small>			

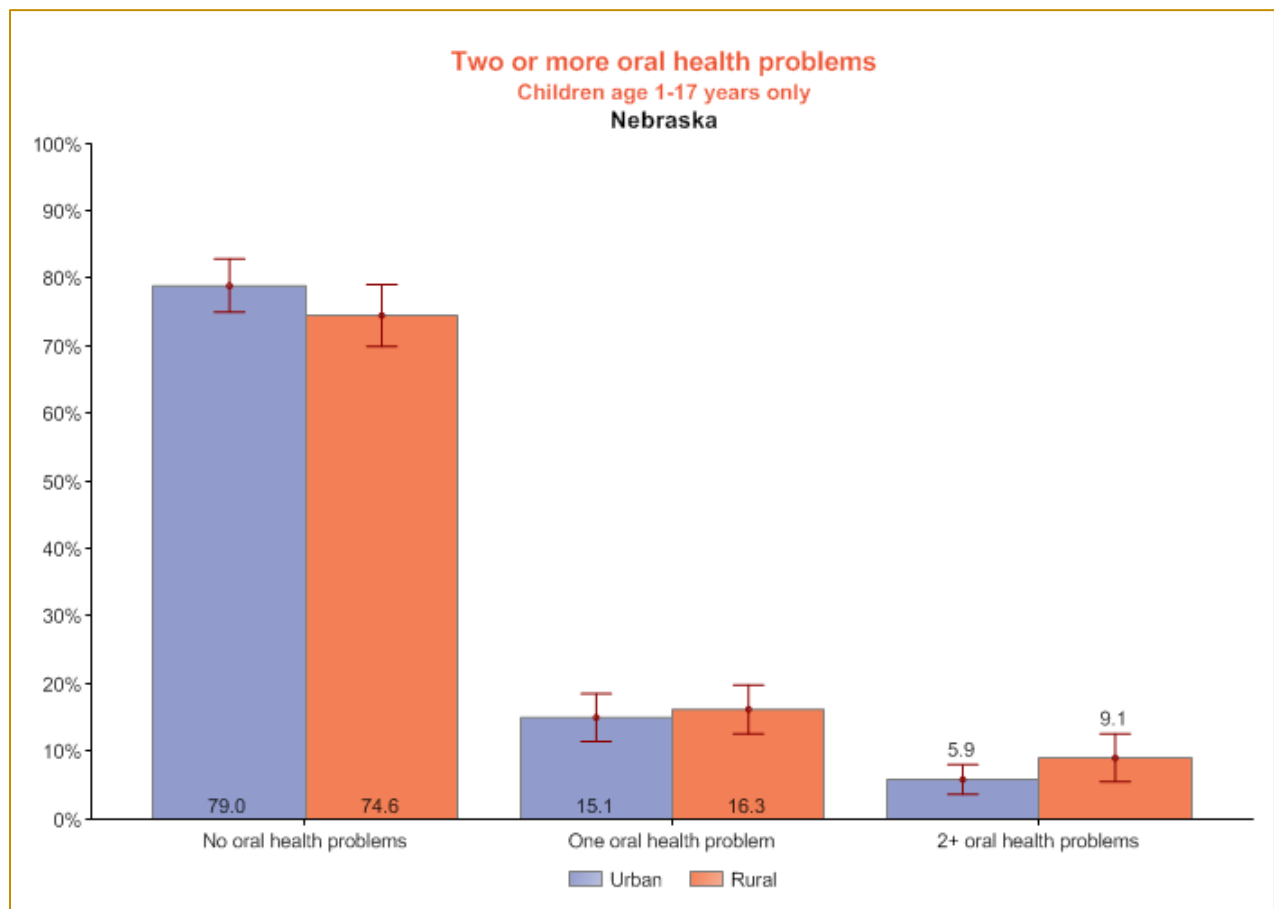


VISIT:
☐ 1ST ☐ 5TH
☐ 2ND ☐ 6TH
☐ 3RD ☐ 7TH
☐ 4TH ☐ 8TH

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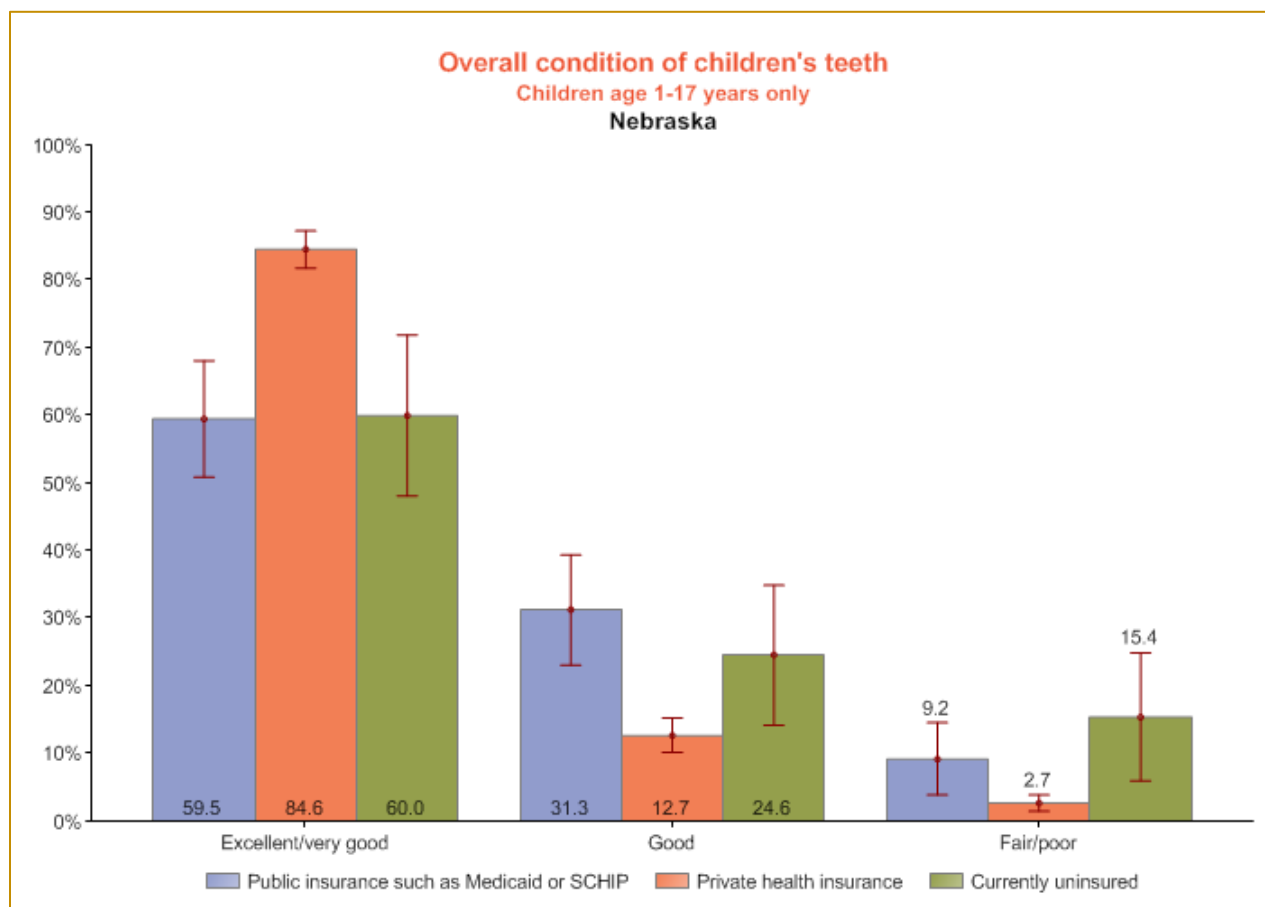
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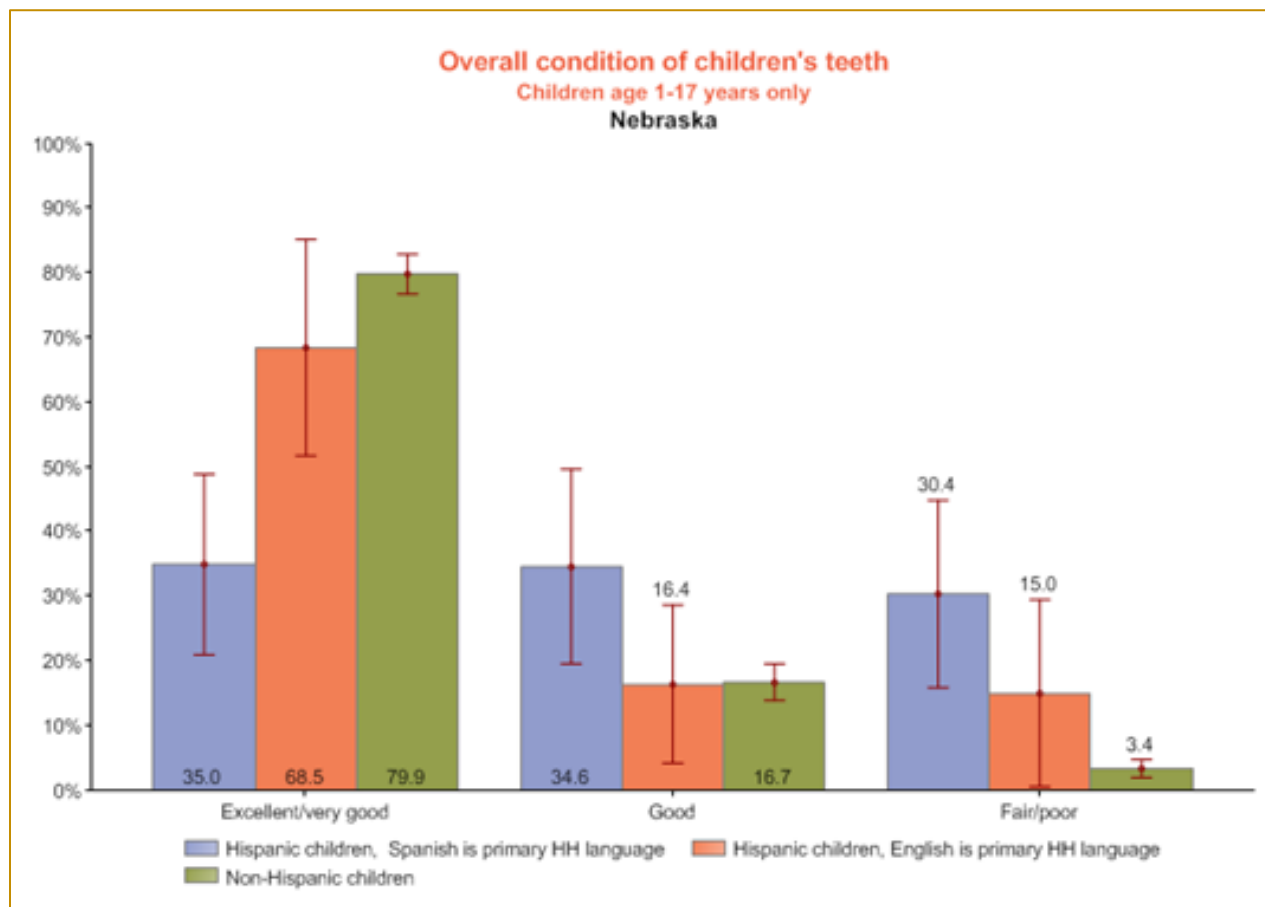
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<http://www.mchoralhealth.org/PDFs/FIVarnishfactsheet.pdf>